DEATHS

BEGINNING 1940

KP 23987

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF _____ BUREAU OF _____ _____ CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. _____ AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6 Size of Record	7 Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals

D. [X] Microfilm and retain originals for length of time indicated below

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10 Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D. Title Commissioner of Health 3/18/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14 Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS:

C P Force 3/18/63
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

447191

G 13251

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

124B

G 13251 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Roslyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Summit Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Pitzer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Elizabeth
6 (c) If alien, give age years
7. Birth date of deceased (mo., day, yr.) 5-22-08
8. AGE: Years 35 | Months 8 | Days 1 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Civil Engineer
11. Industry or business

FATHER
12. Name William H. Pitzer
13. Birthplace Md

MOTHER
14. Maiden Name Virgia Rice
15. Birthplace Md

16 (a) Informant Regular
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26-44 (month) (day) (year)
(c) Cemetery or crematory Dyno Luth.
Location Belair Road

18 (a) Funeral director Wm. J. Connelly
(b) Address 4 E Eastern Ave Govt Hill

19 JAN 24 1944 (Date received by registrar) (b) Huntington Palisades, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jan 23 1944 and that I last saw him alive on Jan 23 1944

Immediate cause of death Hepatic Insufficiency — Duration
due to Portal Thrombosis. Also
Cirrhosis of Liver.
Due to (Banti's Disease)
Due to
Other Conditions Cardiac Hypertrophy
(Include pregnancy within 3 months of death)
Date of operation 1-22-44
Major findings of operation: Hepato-splenomegaly.
of autopsy: Portal Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bennett Jr. M. D.
Address Johns Hopkins Hosp. Date signed 1-24-44

VS 180

correct age is especially important. Physicians: please write the cause in plain words and legibly.

13252 Windle G 13252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 So. Charles St
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 So. Charles (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian S. Windle.

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edgar A. Windle

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1885

8. AGE: Years 58 Months 2 Days 7 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name Julius Arthalon

13. Birthplace Germany

MOTHER 14. Maiden Name Caroline Koppe

15. Birthplace Germany

16 (a) Informant Edgar A. Windle

(b) Address 1629 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.

Location Frederick Ave.

18 (a) Funeral director Fred. J. Krauss & Bro.

(b) Address 2216 S. Charles St.

19 (a) Filed (b) JAN 24 1944 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19, 1944, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17, 1944 to Jan 19, 1944 and that I last saw him alive on Jan 15, 1944

Immediate cause of death	Duration
Cardiac thrombosis	1 day
Due to Coronary Sclerosis	3 yrs
Due to Arteriosclerosis	Life
Other Conditions Hypertension	Life

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Jones M. D.

Address 6 Rennert Date signed 1/24/44

correct age is especially important. Physicians: please write the name in ordinary and legibly.

13253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

730a

G 13253
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 Division St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Y

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Eliza Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1912

8. AGE: Years 31 | Months 9 | Days 11 | If less than one day: hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name B. J. Freeman
13. Birthplace N.C.

MOTHER
14. Maiden Name Eliza Taylor
15. Birthplace N.C.

16 (a) Informant Willie Nelson
(b) Address 1602 Division St.

17 (a) Burial (b) Date thereof 1-24-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lakeview Mem'l
Location Balto Co. Md

18 (a) Funeral director Mrs. Eliz. A. Holland
(b) Address 1631 Druid Hill Ave

19 JAN 24 1944 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19, 1944 to Jan. 21 1944. and that I last saw her alive on Jan. 19, 1944.

Immediate cause of death Pernicious anemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 1-24-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 13254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 N. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 325 N. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ella Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1861

8. AGE: Years 82 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Tuskegee, Ala. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name James Drakeford

FATHER 13. Birthplace Alabama

MOTHER 14. Maiden Name Mary Harris

MOTHER 15. Birthplace Alabama

16 (a) Informant Jennie L. Milton

(b) Address 325 N. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Balto. Md.

18 (a) Funeral director Mrs. Geo. F. Holland

(b) Address 1631 Druid Hill Ave.

JAN 24 1944 (b) Date rec'd by registrar Lemington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20- 1944 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1943 to Jan 24 1944 and that I last saw h[illegible] alive on Jan 18 1944.

Immediate cause of death

Ch. Myocarditis

Due to

Due to

Other Conditions Hypertrophy of Prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. Adger Adams M. D.

Address 312 E 23rd St. Date signed 1-22-44

correct age is especially important. If impossible, please write the nearest estimate in years, months, days, and legibly.

G 13255

G 13255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 52 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Decker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H Seufert.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 9/14/61

8. AGE: Years 82 | Months 4 | Days 8 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER: 12. Name Frank Seufert.
13. Birthplace Germany.

MOTHER: 14. Maiden Name Mary V2.
15. Birthplace Germany.

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schiunski
(b) Address 2601 E. Madison Street

19 JAN 24 1944 (b) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1944, at 12.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1944, to Jan. 22 1944, and that I last saw him alive on Jan. 22 1944

Immediate cause of death Coronary occlusion. — Duration 30 mins.

Due to Arteriosclerotic heart disease

Due to

Other Conditions Papillary carcinoma of urinary bladder

(Include pregnancy within 3 months of death)

Date of operation 1/11/44

Major findings of operations: carcinoma of urinary bladder.

of autopsy: Coronary occlusion.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell B. Roth M. D.
Address Johns Hopkins Hosp. Date signed 1/25/44

VS 150

correct age is especially important. Physicians, please write the name of county and city legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

13256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1628

G 13256

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 N. Chapel Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 N. Chapel Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA KOBER (nee Pavek)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/17/54

8. AGE: Years	Months	Days	If less than one day
89 yrs.	4	5	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant James Kober (son)
(b) Address 820 S. Gay Street

17 (a) Burial (b) Date thereof 1/27/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Hill
Location Phila. Rd. Balto. Co.

18 (a) Funeral director Charles E. Schunert
(b) Address 2601 E. Madison Street

19 JAN 24 1944 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1944 to Jan 27 1944, and that I last saw her alive on Jan 27 1944.

Immediate cause of death

Duration

Due to Senformitis of age — 5 days

Due to Arthritis

Other Conditions Contributory — 10 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Magness M. D.
Address 14 E. Read St. Date signed 1-25-44

.44

13257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13257
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. Randall St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Mary Catherine Cain
3 (b) If veteran, name war —
3 (c) Social Security Account No. 719-03-7455

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife James Cain
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1905

8. AGE: Years 39 | Months — | Days 20 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Patrick H. Rogue
13. Birthplace England

MOTHER
14. Maiden Name Ellen O'Brien
15. Birthplace Ireland

16 (a) Informant James Cain
(b) Address 11 W. Randall St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flanagan
(b) Address 1416 Light St.

JAN 24 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1944 at 2:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1944 to Jan 22 1944, and that I last saw her alive on Jan 21, 1944.

Immediate cause of death Pneumococcic meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Roy Smythe M. D.
Address Mercy Hosp. Date signed 1/22/44

correct age is especially important

VS 180

13258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42a

G 13258 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D O A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Shelby N C
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Samuel Wilson
13. Birthplace N C

MOTHER
14. Maiden Name Mary LaCombs
15. Birthplace N C

16 (a) Informant Effy Wilson Sister
(b) Address 1540 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O Wilson
(b) Address Brantly Pl

JAN 24 1944

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1944, at 6 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Vegetative endocarditis, tricuspid & aortic valves

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 15 1944

VS 181

13259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

G 13259
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 12
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 879 N. Howard St. (If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Nellie Leonard Voigt

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband #### George L. Voigt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1877

8. AGE: Years	Months	Days	If less than one day
66	5 4	10	--- hr. --- min.

9. Birthplace Scranton, Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business ----------

FATHER
12. Name Patrick Leonard
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mr. George L. Voigt
(b) Address 879 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meare & Son
(b) Address 805 N. Calvert St.

JAN 24 1944 (Date rec'd by Registrar) (b) Huntingtown Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-44 19 ... at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15. 1943 to Jan. 22. 1944 and that I last saw ... alive on 1-22- 1944

Immediate cause of death

	Duration
Due to Cerebral Hemorrhage	4 da.
Due to Arteriosclerosis	5 yrs
Other Conditions Myocarditis	5 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno Lut. C. Blake M. D.
Address Med Arts Bldg. Date signed

VS 150

Correct age is especially important. Physicians: please write the CAUSES of death clearly and legibly.

13260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

Registered No. G 13260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 Pierce St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Pierce St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: William Dixon

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1887

8. AGE: Years 56 | Months 11 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Eastern Shore, Md. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business Waiter

FATHER
12. Name Wm. Dixon
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant Blanche Ray(Daughter)
(b) Address 823 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) JAN 24 1944 (date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21/44 19 . at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 19 43 to Jan 24 19 44
and that I last saw h alive on 19

Immediate cause of death
Cellulitis Left Arm
Due to Diabetes

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration
1 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Jan 24 44

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13261 SARTER G 13261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N. Calhoun St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Willie K. Sarter

3 (b) If veteran, name war No

3 (c) Social Security Account No. 246-09-5917

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/16/1920

8. AGE: Years 23 | Months 9 10 | Days 6 | If less than one day hr. min.

9. Birthplace Union, S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Jesse Sarter
13. Birthplace S.C.

MOTHER 14. Maiden Name Addie Sarter
15. Birthplace S.C.

16 (a) Informant Barnie Sarter (Brother)
(b) Address 1625 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/44 (month) (day) (year)
(c) Cemetery or crematory Charlotte Cem.
Location Charlotte N.C.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 JAN 24 1944 (b) [illegible] Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21/44 19 , at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1.19. 1944 to 1. 21. 1944, and that I last saw him alive on 1.21. 1944.

Immediate cause of death Pneumonia — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan O. Sickles M. D.

Address 601 N. Calhoun Date signed 1/24/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 13262
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 Bergundy
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 14yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 Bergundy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Mason

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
G	W.	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-23-44

8. AGE: Years	Months	Days	If less than one day
			11 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Mason
13. Birthplace Phillipsburg, N. J.

MOTHER
14. Maiden Name Catherine Reichard
15. Birthplace Lykens, Pa.

16 (a) Informant Verna Liebold
(b) Address 811 Bergundy, Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JAN 24 1944

18 (a) Funeral director Commissioner of Health

(b) Address

JAN 24 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1944, at 11 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1944 to 1-23-1944, and that I last saw h[illegible] alive on 1-23-1944.

Immediate cause of death atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Mason M. D.
Address Kennedy Hosp Date signed 1-23-44

VS 8

0677

G 13263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

G 13263 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1631 E Monument
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 E. Monument St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Riley Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Geneva Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4 1890

8. AGE: Years 53 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Whitestone, Va. (Town, county, and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER 12. Name Riley Williams Sr.

13. Birthplace Va

MOTHER 14. Maiden Name Alice Upshur

15. Birthplace Md.

16 (a) Informant Geneva Williams

(b) Address 1718 ashland ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/26/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bloomsbury ave

19 (a) 1944 (Delivered or registered) (b) Livingston Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1943, to Jan 22 1944, and that I last saw him alive on Jan 22 1944.

Immediate cause of death	Duration
Apoplexy	
Due to Arteriosclerosis Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward H. Graham M. D.
Address 1631 E. Monument Date signed Jan 24/44

YS 2

G 13264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/1950

G 13264
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N Athol Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N Athol Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis Knipp. (Dennis George Knipp)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 14, 1942

8. AGE: Years	Months	Days	If less than one day
1	8	9	hr. min.

9. Birthplace Madison, Wisc.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name George W. Knipp
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Helen Fawcett
15. Birthplace Balto., Md.

16 (a) Informant Dr. George W. Knipp
(b) Address 4 N. Athol Ave. - 29

17 (a) Burial (b) Date thereof 1/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 24 1944 (Hour of death) Died in Hospital?

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23- 1944, at 9:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strangulation

Due to Meat fibres in Larynx & trachea

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 28/4 at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed 1-23-44

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G 13265 G 13265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Silver Hill Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME PENNIMAN, George N. (George Neilson Penniman)

3 (b) If veteran, name war --

3 (c) Social Security Account No. 215-03-0528

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Natalie S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1891

8. AGE: Years	Months	Days	If less than one day
52	10	21	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business K. & G. Sales Co.

FATHER 12. Name Edward J. Penniman
13. Birthplace Md.

MOTHER 14. Maiden Name Naomi Gosnell
15. Birthplace Md

16 (a) Informant Mrs. Natalie S. Penniman
(b) Address 1914 Silver Hill Ave. - 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1-24 1944 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1944, at 9.10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1944 to 1-22 1944, and that I last saw h[illegible] alive on 1-20 1944

Immediate cause of death Massive hemorrhage

Due to Ruptured saccular aneurism of descending aorta Arteriosclerosis?

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy: Ruptured saccular aneurism of aorta

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. M. Jones Jr. M. D.
Address Univ. Hosp. Date signed 1-24-44

G 13266

G 13266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 149a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Windsor Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Windsor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE A. HOFFMAN

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 705 - 05 - 4855

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1883

8. AGE: Years	Months	Days	If less than one day
60	1	2	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B. & O. R. R.

FATHER
12. Name Dr. John A. Robb
13. Birthplace Ohio

MOTHER
14. Maiden Name Jennie A. Buskirk
15. Birthplace Ohio

16 (a) Informant Mr. James Hoffman
(b) Address 2910 Windsor Ave. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 24 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1943 to Jan 23 1944 and that I last saw h alive on Jan 22 1944.

Immediate cause of death Carcinoma of Ovary.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation July 1943
Major findings of operations no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Seegmiller M. D.
Address 1729 W Lombard St Date signed 1-24-44

Cancer age is especially important. Physicians please write plainly.

G 13267 G 13267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) Hospital or institution:
Crawford Nurs. Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Balto. 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME MARGARET P. FRAZEE

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Harrison W.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1893

8. AGE: Years 50 | Months 2 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John A. Staph
13. Birthplace Md.

MOTHER
14. Maiden Name Katie Moore
15. Birthplace Md.

16 (a) Informant Mr. Clarence Frazee
(b) Address 4910 Queensbury Ave. 15

17 (a) Burial (b) Date thereof 1/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ..... (b) ..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1944, to 1/22 1944, and that I last saw her alive on 1/21 1944.

Immediate cause of death: 1 Hypostatic pneumonia — Duration 2 days
Due to Cancer of the rectum 2 yrs
2 metastases.
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation 6/43
Major findings of operation: Cancer of rectum & metastases
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature T. J. Regan M. D.
Address 3629 Edmondson Date signed 1/24/44

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Note H

To be O. K'd. by Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

JL - 81133 G 13268 CERTIFICATE OF DEATH 186a Registered No. G 13268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or Institution? Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 1
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Florence Crevensten

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 10, 1859

8. AGE: Years	Months	Days	If less than one day
84	9	12	hr. min.

9. Birthplace Md. - Aberdeen (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name George Cravenaten
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Walsh
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/44 (month) (day) (year)
(c) Cemetery or crematory Grove Cem., Location Aberdeen, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 24 1944 (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1944, at 5-20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1943, to 1-22 1944, and that I last saw h[illegible] alive on 1-22 1944.

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to Arteriosclerotic Cardio-Vascular Disease	?
Due to Fracture Neck of Femur	9 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-24-43
Major findings of operations: Fracture of Femur
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental Fall
(b) Date of occurrence 4-22-43 at 12/3 M
(c) Where did injury occur? Balto (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Accidental Fall

23. Signature Donald Postell M. D.
Address Balto City Hosp Date signed 1-22-44

Dr. Wollenweber MD

3269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 13269
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1944

8. AGE: Years	Months	Days	If less than one day
0	0	12	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Dorothy L. Brown
15. Birthplace Md.

16 (a) Informant Dorothy L. Brown
(b) Address 535 Dolphin St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JAN 24 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1944, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1944 to Jan 14 1944, and that I last saw him alive on Jan 14 1944.

Immediate cause of death — Duration

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Meyer Conkling M. D.
Address Date signed

0678

G 13270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13270 Registered No. 1228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town rural (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Magalene Butler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	6		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Woodlawn Park Cemetery
Location St. Mary's Co.
18 (a) Funeral director W. C. Matthews & Son
(b) Address Leonardtown, Md.

JAN 24 1944 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1944 to 1-23 1944 and that I last saw her alive on 1-23 1944

Immediate cause of death: Shock — Duration

Due to Intussusception

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thornton Pfeil M. D.
Address Univ. Hosp. Date signed 1/23/44

VS 180

Please write age in years if possible. Physicians: please write the causes of death clearly and legibly.

G 13271

G 13271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2232 E. Oliver St.

(c) Hospital or institution At Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. 2232 E. Oliver St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara E. Woolley

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Milton J. Woolley

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Oct. 16 1914

8. AGE: Years	Months	Days	If less than one day
29	3	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Forelady

11. Industry or business Hose & Dresses

FATHER 12. Name John Brockmeyer

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Meyers

15. Birthplace Baltimore Md

16 (a) Informant Mrs. Milton J. Woolley

(b) Address 2232 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4430 Belair Road

18 (a) Funeral director Edgar W. Coddington Son

(b) Address 924 E. Eager St.

19 (c) JAN 24 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1944, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943, to Jan. 23 1944, and that I last saw her alive on Jan. 23 1944.

Immediate cause of death Carcinomatosis — Duration

Due to Adeno carcinoma of the stomach (?) — 3-4 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Biopsy of Cervical Gland at Johns Hopkins

Major findings of operation Metastasis, Adeno carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. K. Grossman M. D.

Address 1124 N. Patterson Pk Ave Date signed 1/24/44

G 13272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G 13272 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Old Frog Lane
(c) Hospital or institution: Old Liberty Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 E. Lafayette Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Godwin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Josephine B. Godwin
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 3-1862

8. AGE: Years	Months	Days	If less than one day
81	2	20	hr. min.

9. Birthplace Carroll Co Md.
(Town, county, and state)

10. Usual Occupation Tool

11. Industry or business

FATHER 12. Name Joseph Godwin
13. Birthplace Md

MOTHER 14. Maiden Name Mary Faust
15. Birthplace Md

16 (a) Informant Mrs E. Godwin
(b) Address Pikesville Md

17 (a) Burial (b) Date thereof Jan 26 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Md
Location Reisterstown Md

18 (a) Funeral director Peter Boyle
(b) Address 2234 N Charles St

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1944 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1944 to Jan 23 1944, and that I last saw him alive on Jan 20 1944.

Immediate cause of death	Duration
Carcinoma of Gallbladder	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel D Wolfe M. D.
Address 1311 E Lafayette Ave Date signed 1-24-44

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13273

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. G 13273

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 S. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 S. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Gibson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie S. Gibson
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Oct 18, 1893

8. AGE: Years	Months	Days	If less than one day
50.	3.	4.	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Baby Yard Work D.C.

FATHER
12. Name William M. Gibson
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes Wood
15. Birthplace Md.

16 (a) Informant Mrs. Annie S. Gibson
(b) Address 1116 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave.

18 (a) Funeral director John J. Cowan & Son
(b) Address 1103 Baltimore Street
(c) Filed 1/24/44 (Date rec'd by registrar) (Signature) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22/1944, at 9:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 20 1944 to Jany 22 1944
and that I last saw him alive on Jany 22 1944

Immediate cause of death	Duration
Bi Lateral Bronchopneumonia	
Due to Acute Cardiac Dilatation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. J. Kirby
Address 110 E. Fort Ave. Date signed 1/23/44

KIRBY

G 13274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 13274 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2233 Penrose Ave
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 Penrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth C. Schaeb

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Widower

6 (b) Name of husband or wife Late Adolph Schaeb
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1850

8. AGE: Years	Months	Days	If less than one day
93.	1	10	hr. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation Houswork
11. Industry or business at home

FATHER
12. Name Ignatius Seibi
13. Birthplace Germany.

MOTHER
14. Maiden Name Aylenopax.
15. Birthplace Germany.

16 (a) Informant Mrs. Clara M. Miller
(b) Address 2233 Penrose Ave

17 (a) burial. (b) Date thereof 1/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director John Conway & Son
(b) Address 901 W. Fayette Street

19 (a) JAN 24 1944 Registrar
(Date rec'd by registrar)

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22, 1944, at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944 to Jan 22 1944 and that I last saw h[illegible] alive on Jan 21 1944.

Immediate cause of death Arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Leopold M. D.
Address 1724 W Lombard Date signed 1-24-44

G 13275

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 72a

G 13275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Rural Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Bernagozzi

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Overlus Bernagozzi
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1876

8. AGE: Years 67 | Months 3 | Days 24 | If less than one day: hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Darius Zeeser
13. Birthplace Maryland.

MOTHER
14. Maiden Name Susanna Reinecke
15. Birthplace Maryland

16 (a) Informant Overlus Bernagozzi
(b) Address Westminster (Rural)

17 (a) Burial (b) Date thereof 1-27-44 (month) (day) (year)
(burial, cremation, or removal)

(c) Cemetery or crematory Meadow Branch Cem.
Location Westminster, Md

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md

19 (a) (Date received by registrar) JAN 24 1944 (b) Huntington Williams, Registrar
VS-13a

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1944, at 5:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1944 to 1-23 1944, and that I last saw h[illegible] alive on 1-23 1944

Immediate cause of death Multiple Hemorrhages — Duration

Due to Thrombocytopenia — Duration

Due to Aplastic Anemia — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A. M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

23. Signature H. M. Lowe Jr. M. D.
Address Union Hosp. Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13276 ✓ G 13276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

937

1. PLACE OF DEATH ALHAMBRA APTS. Registered No.

CITY OF BALTIMORE: (No. Alhambra Apts 1H Ward) (Lake Drive)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Amelia Marks (AMELIA MARKS.) If U. S. Veteran specify WAR

(a) Residence: No. Alhambra Apts-1H St., Ward.
(Usual place of abode) (Lake Drive) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Marks

6. DATE OF BIRTH (month, day, year) May 25 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	7	30	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Germany

FATHER

13. NAME

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Amelia Samuels

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mrs. Lena Gershon (MRS. LENA GERSHON)
(Address) Lake Drive Apts.

18. BURIAL, CREMATION, OR REMOVAL West View Cemetery Date Jan 26 1944
(ATLANTA)

19. UNDERTAKER Atlanta Ga.
(Address) J. Aberbach & Co. 432 Reisterstown Rd

20. FILED JAN 24 1944 Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 1/24, 1944

22. I HEREBY CERTIFY, That I attended deceased from 1/05, 1944 to 1/24, 1944

I last saw her alive on 1/23, 1944 Death is said to have occurred on the date stated above, at 9:45 A m.

The principal cause of death and related causes of importance were as follows:

	Interval between onset and death
Pulmonary edema	1/23/44

Other contributory causes of importance:

General arterio sclerosis	10 yrs
Myocardial insufficiency	5 yrs

Was an operation performed? No Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Frank Levinson, M. D.

(Address) 4004 Talbot Hgts Rd

13277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 13277
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Hospital For Women of maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Hanover
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Sprenkle Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Anna May Wege

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/1882

8. AGE: Years 61 | Months 6 | Days 9 | If less than one day 0 hr. 17 min.

9. Birthplace Hanover, Penn.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Wege.
13. Birthplace Hanover.

MOTHER
14. Maiden Name Anna Wise.
15. Birthplace Hanover

16 (a) Informant Herald Wege.
(b) Address Hanover Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27 1944 (month) (day) (year)

(c) Cemetery or crematory not Olivet
Location Hanover Pa.

18 (a) Funeral director W. G. Fuser

(b) Address Hanover Pa.

JAN 25 1944
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1944 to 1/25 1944 and that I last saw her alive on 1/25 1944.

Immediate cause of death
Pulmonary edema
Cardiac failure
Due to Respiratory embarrassment
Due to Recurrent carcinoma of breast

Duration: 9 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/15 1944

Major findings of operation: Carcinoma of Thorax and metastases

Autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Felix N. Rutledge M. D.

Address Hosp. for Women of Md. Date signed 1/26/44

VS 3

Correct age is especially important. Physicians: please write the cause of death plainly.

13278
447852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131W

G 13278
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 W Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isom Baker
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: Edna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-8-98
8. AGE: Years 45 Months 2 Days 15 If less than one day hr. min.
9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Riley Baker
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-44 (month) (day) (year)
(c) Cemetery or crematory Greenville N.C.
Location N.C.

18 (a) Funeral director George H. Kelson
(b) Address 1303 Pennsylvania Ave

19 JAN 25 1944 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 23 1944, at 925 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 17 1944 to JAN 23 1944 and that I last saw HIM alive on JAN 23 1944.

Immediate cause of death: Respiratory failure — Duration: 4 yrs

Due to: Hypertensive arteriosclerotic Heart disease & nephritis & cardiac failure — Duration: 5 yrs.

Other Conditions: bleeding stopped when bleeding bronchus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cohen M. D.
Address Johns Hopkins Date signed 1-25-44

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 13279

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1327 E. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Irene Cross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband Willard F. Cross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28th 1861

8. AGE: Years	Months	Days	If less than one day
82	3	25	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Tracey

13. Birthplace

MOTHER 14. Maiden Name Henrietta Mallonee

15. Birthplace Butler Md

16 (a) Informant Mrs Ina Agreda

(b) Address 1327 E. North Ave

17 (a) Burial (b) Date thereof 1/26/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Jesups M. E. Church

Location Cockeysville Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 S. Paul St

JAN 25 1944 Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23rd 1944 at 11:50 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1943 to Jan 23 1944 and that I last saw h.e alive on Jan 21 1944

Immediate cause of death

Chronic Myocarditis

Due to Arteriosclerotic Cardio-Vascular Renal Disease

Duration: 2 yrs, 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl B Wolfe M. D.

Address 1111 Shoreham Date signed 1-24-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G 13280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5039 Reisterstown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5039 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche P. Cannoles

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-03-6169

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. D. Cannoles
6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 18th 1888

8. AGE: Years: 55 | Months: 5 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (town, county, and state)
10. Usual Occupation: Laundress
11. Industry or business: Md. Jockey Club

FATHER
12. Name: Benjamin F. Waggington
13. Birthplace: Va.

MOTHER
14. Maiden Name: Emma V. Ross
15. Birthplace: Balto Md.

16 (a) Informant: Emma V. Smith
(b) Address: 5270 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/25/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

JAN 25 1944 (Date rec'd by registrar)
(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21st 1944, at 8 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1943 to Jan. 21 1944, and that I last saw her alive on Jan. 21 1944.

Immediate cause of death
1) - Lymphosarcoma — Duration: 9 months

Due to

Due to

Other Conditions - Secondary anemia — 6 mos.
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: - None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Earl L. Chambers M. D.
Address 4108 Liberty Hts. Ave. Date signed 1/24/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

13281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 13281
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 Busk St
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 Busk St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William N. Dreer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Sallie B. Dreer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4th 1868

8. AGE: Years	Months	Days	If less than one day
75	10	14	hr. min.

9. Birthplace Queen Annes Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Elliott Machine Co

FATHER
12. Name Nicholas Dreer
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Van Sant
15. Birthplace Md.

16 (a) Informant Albert N. Dreer
(b) Address 1529 Busk St

17 (a) Burial (b) Date thereof 1/26/44
(Burial, ~~cremation or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

JAN 25 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23rd 1944, at 4 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1944 to Jan 23 1944 and that I last saw him alive on Jan 23 1944.

Immediate cause of death Bronchopneumonia. — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Schofield
Address [illegible] Date signed 1/24/44

correct age is especially important. Physicians: please write the cause of death plainly.

13282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 13282
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 Pressman St.
(c) Hospital or Institution: Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16/7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 S. Pressman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT BYRNES.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/44.

8. AGE: Years	Months	Days	If less than one day
		1	9 hr. 45 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Vincent A Byrnes
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Metzger
15. Birthplace Baltimore Md

16 (a) Informant Vincent A Byrnes
(b) Address 312 Pressman St

17 (a) Burial (b) Date thereof 1/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul Cem
Location Balto Md.

18 (a) Funeral director Mayer E. Frackowiak
(b) Address 1041 Kenwood Ave

19 (a) JAN 25 1944 (b) Huntington Williams
(Registrar's signature) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1944, to Jan. 24 1944, and that I last saw him alive on Jan. 23 1944.

Immediate cause of death Atelectasis
Duration 3½ hours

Due to Premature

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel B Wolfe M. D.
Address 1331 E Baltimore Ave Date signed 1-24-44

correct age is especially important. Physicians: please write out causes of death.

13283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G 13283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233 S. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 3
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 233 S. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Eckman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	white	widower

6 (b) Name of husband or wife Late Amanda E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1869

8. AGE: Years	Months	Days	If less than one day
74	4	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired Railroad Conductor
11. Industry or business B & O. R. R.

MOTHER / FATHER
12. Name Daniel M. Eckman
13. Birthplace Maryland
14. Maiden Name Margaret McNamee
15. Birthplace Virginia

16 (a) Informant Mr. Harry R. Eckman
(b) Address 233 S. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd.

18 (a) Funeral director Harry H. Wittke
(b) Address 4101 E. Monument Ave

19 (d) JAN 25 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1944 at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 25 1944 to Jan 22 1944 and that I last saw him alive on Jan 22 1944.

Immediate cause of death Mitral Insufficiency — Duration ?
Due to Cerebral Thrombosis — 1/18/44
Due to Arteriosclerosis — ?
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carey Rostney M. D.
Address 324 W. Lombard St. Date signed 1/24/44

Registrar for Williams, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly.

13284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

G 13284
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2130 Penrose Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 Penrose ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Linda Lee Elizabeth Lawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1943

8. AGE: Years	Months	Days	If less than one day
	6	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Paul A. Lawson, Jr
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Maria Kalb
15. Birthplace Balto. Md.

16 (a) Informant Paul A. Lawson, Jr
(b) Address 2130 Penrose ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick ave

18 (a) Funeral director Harry H. Mitchell
(b) Address 4101 Edmondson Ave

19 (a) JAN 25 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1944, at 3:23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1944 to 1/23 1944 and that I last saw h alive on 1/20 1944

Immediate cause of death Spina Bifida & Hydrocephalus — Duration 6 mo

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. F. Sutinski M. D.
Address 5017 Bannett Rd Date signed 1/23/44

VS 150

G 13285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13285 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Sanford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred H. Liebhardt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/13/1889

8. AGE: Years 54 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Stock clerk

11. Industry or business Lucas Bros.

12. Name Carl Liebhardt

13. Birthplace Germany

14. Maiden Name Mary Warner (Werner)

15. Birthplace Germany

16 (a) Informant Gertrude White

(b) Address 130 Sanford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Edw. J. Mac Nabb

(b) Address Catonsville, Md.

JAN 25 1944 (Date rec'd by registrar) (b) 0 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1944, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed January 25, 1944

VS 151

13286 Tabler ✓ C 13286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 83a

1. PLACE OF DEATH Edgewood Nursing Home

CITY OF BALTIMORE: (No. 6000 Belevue Ave St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran specify WAR —

2. FULL NAME Nellie Tabler

(a) Residence: No. Ellicott City Md. St., Ward Howard County

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) Sept 20, 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	4	20 3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. "

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) W Va.

FATHER

13. NAME Alonzo J P Tabler

14. BIRTHPLACE (city or town) (State or country) W Va.

MOTHER

15. MAIDEN NAME Ann E Hughes

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Guy Sykes

(Address) Ellicott City Md.

18. BURIAL, CREMATION, OR REMOVAL

Place London Park Balto Date 1-26 1944

19. UNDERTAKER J.C. Kinsthorn

(Address) Ellicott City Md

20. FILED JAN 25 1944 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan. 23 1944

22. I HEREBY CERTIFY, That I attended deceased from Jan 10 1944 to Jan 23 1944

I last saw him alive on Jan 23 1944. Death is said to have occurred on the date stated above at 12:30 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Paralysis	13 days
Cerebral Hemorrhage	1 day

Other contributory causes of importance:

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? —

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury — 19—

Where did injury occur? — (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No If so, specify —

(Signed) D A Richardson M. D.

(Address) 112 W. Saratoga St

13287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

G 13287
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co.
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Powhatan Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Courtland A. Baker

3 (b) If veteran, name war None

3 (c) Social Security Account No. 222-09-9815

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elaica

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1901

8. AGE: Years 42 Months 7 Days 18
If less than one day hr. min

9. Birthplace Easton, Md.
(Town, county, and state)

10. Usual Occupation guard

11. Industry or business Md. Drydock

FATHER
12. Name Chas Benson Baker.
13. Birthplace Preston Md.

MOTHER
14. Maiden Name Ida Raynell Andrews
15. Birthplace Easton, Md.

16 (a) Informant Mrs. Mable Baker Maloney
(b) Address Phila, Pike, Claymont, Del

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN, 27, 1944 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Memo.
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie Md.

JAN 25 1944 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1944, at 12 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1944 to 1-24 1944.
and that I last saw h[illegible]M. alive on 1-24 1944.

Immediate cause of death Pulmonary embolism

Duration

Due to thrombosis at operative site

Due to

Other Conditions Ruptured appendix
(Include pregnancy within 3 months of death)

Date of operation 1-8-44

Major findings of operation: Appendiceal abscess - ruptured app.

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Stier M. D.
Address St Agnes Hosp. Date signed 1-24-44

VS 150

Correct age is especially important. If unknown, please write the words "age unknown" clearly and legibly.

Spec.—9-39—A. & Co.—200 Blks.

13288

G 13288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

937

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 N. Wolfe ST. WARD) 9-1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Dalton

(a) RESIDENCE NO 1104 N. Wolfe ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Dalton

6 DATE OF BIRTH (month, day, and year) 1889 Sept

7 AGE	Years	Months	Days	IF LESS than 1 day, hrs. or min.
	54	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Deborah Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Joseph Dalton 1104 N. Wolfe St

15 JAN 25 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/23/44

17 I HEREBY CERTIFY, That I attended deceased from 1-17 1944 to 1-23 1944 that I last saw him alive on 1-23-44 19..

and that death occurred, on the date stated above, at 6:30a m.

The CAUSE OF DEATH* was as follows:

(1) Pulmonary Edema

Acute myocarditis

(duration) yrs. mos. 2 ds. Heart

CONTRIBUTORY (Secondary) Chr. Cardio-vascular Renal (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dow. D. Lay Berry M. D.

(Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL 1/27/44

UNDERTAKER Robert E. Williams ADDRESS 1515 E. Eager St

13289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G 13289

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N. Dallas Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 40? | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Gilbrist
13. Birthplace Va

MOTHER
14. Maiden Name Annie Nash
15. Birthplace Balto Md

16 (a) Informant Samuel Curry
(b) Address 407 N Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) JAN 25 1944 (Date rec'd by registrar) (b) Huntington Md (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13- 1944, at 10 15 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-13-44 at 9.45 P. M. 6/5
(b) Where did injury occur? Fayette St. at Bond St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? [illegible]
(d) Means of injury Pedestrian, struck by auto truck

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 1-14-44

VS 151

13290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 13290

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4303 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4303 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Riccardo Magnanini

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-61-6238

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Virginia Magnanini
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28-1881

8. AGE: Years	Months	Days	If less than one day
62	3	25	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Stonecutter
11. Industry or business Retired

FATHER
12. Name Unknown -
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown -
15. Birthplace Italy

16 (a) Informant Loretta Magnanini
(b) Address 4303 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director George Lakilling & Son
(b) Address 2424 Greenmount Ave

JAN 25 1944 (Date rec'd by registrar)

(b) Washington Matthews, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23rd 1944, at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to 1/23 1944 and that I last saw h alive on 1/23 1944.

Immediate cause of death	Duration
Hypertension	
Cardio - Vascular Disease	
Due to	
Due to	
Other Conditions Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Klaus A. Kelley M. D.
Address 6703 Harford Rd Date signed 1/24/44

VS 3

13291

JL - 64546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C 13291

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 9 - 1

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 915 McDonald St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Melvin Slocum

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-8522

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1900

8. AGE: Years	Months	Days	If less than one day
43	?	?	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name William Slocum

13. Birthplace Dorchester Co Md

MOTHER — 14. Maiden Name Mary McCready

15. Birthplace Dorchester Co Md

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25-1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location A. A. Co Md

18 (a) Funeral director Robert E Williams

(b) Address 15-15 McElderry St

19 (a) JAN 25 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 1/19 1944.

and that I last saw him alive on 1/19 1944.

Immediate cause of death Uraemia

Bronchopneumonia (?)

Due to H.C.V.D.

Due to

Other Conditions old hemi-

plegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. J. Seymour M. D.

Address BCH Date signed 1/24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as age is especially important. Physicians: please write the causes of death clearly and legibly.

13292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

✓ G 13292

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered, or the certificate will be returned for correction. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2515 Hollins St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 62-9-11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2515 Hollins St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES-JOSEPH-HAGAN-

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-01-1078

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Dead.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, and yr.) April 8 1881

8. AGE: Years 62 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Canning Trade

FATHER 12. Name Peter Hagan

FATHER 13. Birthplace Balto Md.

MOTHER 14. Maiden Name Mary Mulligan

MOTHER 15. Birthplace Balto Md

16 (a) Informant David Lawlor

(b) Address 2515 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Edmondson Ave

18 (a) Funeral director Geo Leupold

(b) Address 1726 N Eutaw St

19 (a) JAN 25 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1944, at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1936 to Jan 23 1944 and that I last saw h alive on 19

Immediate cause of death Pulmonary Tuberculosis — Duration 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Cales M. D.

Address 427 Fulton Date signed

13293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G 13293
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 841 E Chase St
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0.0.0.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 841 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Shoemack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 1865

8. AGE: Years 78 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Shoemark
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Mrs C A Friedrich
(b) Address 409 Edmondson Ave, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Charles P Powell
(b) Address 1427 Edmondson Ave

JAN 25 1944 (Date rec'd by registrar) Registrar of Vital Statistics

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1944, at 10:00 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 24, 1944 10:00 A.M.
(b) Where did injury occur? 841 E. Chase St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Inhaled illuminating gas

23. Signature Robert Lee Fentress M.D. Medical Examiner.
Date signed January 24, 1944

correct age is especially important. Physicians, please

VS 181

G 13294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13294

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate in order to secure a correct record. Accuracy in the statement of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 W. Hennetta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4. W. Hennetta St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ann Gilliam

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Child

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1943

8. AGE: Years	Months	Days	If less than one day
1		13	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Calvin Gilliam
13. Birthplace N. C.

MOTHER
14. Maiden Name Annie Bond
15. Birthplace N. C.

16 (a) Informant Annie Gilliam (M)
(b) Address 4 W Hennetta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 1014 W Montgomery St

19 (a) 1-25-1944 (Date received by Registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1944 at 1 10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/16 1944 to 1/21 1944, and that I last saw h[illegible] alive on 1/21 1944.

Immediate cause of death acute Bronchopneumonia 5 days
Due to Whooping Cough
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/25/44

G 13295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§ 3a

G 13295 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Northern Pky (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F Dasch

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary J
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 28, 1861

8. AGE: Years: 82 | Months: 8 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name? Peter Dasch
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant: Harry A. Dasch
(b) Address: 1916 W. York St Phil. Pa. 32

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 26 44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd

18 (a) Funeral director: Mark W. La Rippelle's Sons
(b) Address: 7110 Belair Rd

19 (a) Date received: JAN 27 1944 (b) Registrar: Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1944, at 6 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1944 to Jan 23 1944 and that I last saw h.i.m. alive on Jan 23 1944.

Immediate cause of death: Hypostatic pneumonia — Duration
Due to: Hemiplegia (left side)
Due to: Cerebral vascular accident
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan
Address St Joseph's Hospital Date signed M.-D.- 23-44

G 13296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

G 13296
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 E. 41st Street
(c) Hospital or institution:

91

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 E. 41st Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Wheltle

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband ~~or wife~~ Charles B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13 - 1868

8. AGE: Years	Months	Days	If less than one day
75	9	10	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nicholas Swisler
13. Birthplace

MOTHER
14. Maiden Name Christina Kries
15. Birthplace

16 (a) Informant Alberta Biddison
(b) Address 801 E. 41st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Rd.

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Eastern Ave

JAN 25 1944 (Date Rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1944, to Jan 23 1944, and that I last saw h[illegible] alive on Jan 23 1944

Immediate cause of death	Duration
Sepsis, Endocarditis	8 days
Due to Chronic Rheumatism	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C B Wheltle
Address 1279 Fillmore St Date signed 1/24/44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

WHELTLE

13297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

✓ G 13297 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 N. Eden St
(c) Hospital or institution:

10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice H. Greene

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Rev Albert J. Greene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1868

8. AGE: Years	Months	Days	If less than one day
76	6	15	hr. min.

9. Birthplace Hooker Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hillary Wyatt
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Carter
15. Birthplace Va.

16 (a) Informant Alice Wyatt
(b) Address 1729 MC Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Am
Location A. A. County Md

18 (a) Funeral director Mrs. Roberts & Elbert Dyer
(b) Address 1129 N. Gay Street

JAN 25 1944 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1944 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to Jan 22 1944.
and that I last saw h.. alive on Jan 22 1944.

Immediate cause of death Chronic Nephritis — Duration 1 yr

Due to (uremia)

Due to

Other Conditions Mitral Insufficiency — 1 yr

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph J. Young M. D.
Address 424 E Monument St Date signed 1/23/44

* Information as to correct age is especially important. Physicians: please write the cause of death clearly and legibly.

298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 13298
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Dorchester Rd.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 83 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Dorchester Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Mary Augusta Kinsey

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband #### Josiah A. Kinsey
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) 1/23/1860

8. AGE: Years	Months	Days	If less than one day
84	0	0	### hr. ### min.

9. Birthplace Easton, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business ----------

FATHER
12. Name John Bagnelle
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma D. Manner
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Louise R. Kinsey
(b) Address 3907 Dorchester Rd.

17 (a) Burial (b) Date thereof 1/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert St.

19 JAN 25 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1944, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1943 to 1/23 1944 and that I last saw h[illegible] alive on 1/23 1944.

Immediate cause of death Arterio Sclerosis — Duration 38d

Due to Cerebral Hemorrhage — Duration 1hr

Due to ----------

Other Conditions ----------

(Include pregnancy within 3 months of death)
Date of operation ----------
Major findings of operation: ----------
of autopsy: ----------

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ----------
(b) Date of occurrence ---------- at ---------- M
(c) Where did injury occur? ----------
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---------- While at work? ----------
(Specify type of place)
(e) Means of injury ----------

23. Signature W. S. Gamble M.D.
Address 6 W 7th. St. Date signed 1/25/44

VS 180

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure that the information given in items 20 to 22 is correct and complete. Accuracy in the statement of the cause of death is especially important.

13299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13299
Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 270 BELLEAU CT.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days) 1 YEAR

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 270 BELLEAU CT. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES MIDDLETON

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARY MIDDLETON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 30 1892

8. AGE: Years	Months	Days	If less than one day
51	11	23	hr. min.

9. Birthplace EELL MD. (Town, county, and state)
10. Usual Occupation BOARDING HOUSE KEEPER
11. Industry or business FOR SELF

FATHER
12. Name ASBURY MIDDLETON
13. Birthplace VA.

MOTHER
14. Maiden Name MAY CORBIN
15. Birthplace MD.

16 (a) Informant MARY MIDDLETON (WIFE)
(b) Address 270 BELLEAU CT. (Belleau Ct)

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 27/44 (month) (day) (year)
(c) Cemetery or crematory EELL CEM.
Location EELL MD.

18 (a) Funeral director John J. Bradshaw
(b) Address CRISFIELD MD.

19 (a) JAN 25 1944 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 23 1944 at 7/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1944 to Jan. 23 1944 and that I last saw him alive on Jan. 23 1944

Immediate cause of death	Duration
Coronary Thrombosis	48 hrs.
Due to Cerebral Hemorrhage	?
Coronary Arteriosclerosis	
Due to over obesity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary J. Dempsey M. D.
Address 700 E. Pratt St. Date signed 1/24/44

3300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G 13300
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3204 FLEET ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 FLEET ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE J. KISPERT

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 212-09-0918

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife HELEN KISPERT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 1 1886

8. AGE: Years 57 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation BLACKSMITH

11. Industry or business SCHWIENTTECK.

FATHER 12. Name KISPERT

13. Birthplace GERMANY

MOTHER 14. Maiden Name MARY SENSER

15. Birthplace GERMANY

16 (a) Informant HELEN KISPERT (WIFE)

(b) Address 3204 FLEET ST.

17 (a) BURIAL (b) Date thereof JAN. 27/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory SACRED HEART CEM.

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Riker INC.

(b) Address 403 S. WOLFE ST.

19 (a) JAN 25 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 24 1944, at 8/30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1942 to Jan 24 1944.
and that I last saw h, alive on Jan 23 1944.

Immediate cause of death Hypertension
Arteriosclerotic C-V. Disease
Cerebral Hemorrhage

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
12-15-42
1-22-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence None at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Schwientteck M. D.

Address 842 S. Castle Date signed 1-24-44

PLEASE WRITE correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13301 G 13301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. YA 96533

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 E. York St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Warner

3 (b) If veteran, name war:

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/1898

8. AGE: Years 45 | Months 6 | Days 19 | If less than one day: hr. min.

9. Birthplace Panama Canal Zone (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business 618 S. Hanover St.

FATHER
12. Name Robert Warner
13. Birthplace West Indies

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Darco. Md

18 (a) Funeral director James A. Hayes
(b) Address 142 N. Steel St

JAN 25 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1944, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1943 to 1/22 1944 and that I last saw h/ alive on 1/22 1944

Immediate cause of death: Ruptured aneurism of heart — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Mattman M. D.

Address B. C. H Date signed 1/23/44

3302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 13302
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Ward or address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Burgundy ~~Street~~
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolina Fauntleroy

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Richmond, Va
(Town, county, and state)

10. Usual Occupation none
11. Industry or business

FATHER
12. Name Junius Traylor
13. Birthplace Va

MOTHER
14. Maiden Name Susanna —
15. Birthplace Va

16 (a) Informant Areata Waters
(b) Address 513 Burgundy St

17 (a) Burial (b) Date thereof Jan 26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Co. Md

18 (a) Funeral director James Rastaya
(b) Address 1422 West St

JAN 25 1944
(Date rec'd by registrar)
(b) Huntington Williams U.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22- 1944, at 3 30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage, Spontaneous
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maldeis M.D.
Medical Examiner.
Date signed 1-23-44

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3303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 13303

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 Bradley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Bradley St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Jones
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Wm. Jones
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1880
8. AGE: Years 63 | Months | Days | If less than one day hr. min.
9. Birthplace Calvert Co (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Wm. Golder
13. Birthplace Md.

MOTHER
14. Maiden Name Agnis (?)
15. Birthplace Md.

16 (a) Informant Emma Blake
(b) Address 836 Bradley St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director James A Stango
(b) Address 1424 Pitcher St
JAN 25 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1944 at 7:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1943 to Jan 23 1944 and that I last saw her alive on Jan 21 1944
Immediate cause of death Chr. Cardio-renal disease. — Duration 5 mo.
Due to Unknown
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John W. Grimes M.D.
Address 665 W. Barre St Date signed 1/25/44

VS 150

Correct ages as indicated. Important: Please write the causes of death clearly and legibly.

3804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13304

Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 S. BROADWAY
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 S BROADWAY (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVA GOLDSTEIN

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced M
6 (b) Name of husband or wife Harry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 1881

8. AGE: Years 62 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Mom
11. Industry or business

MOTHER / FATHER
12. Name Abraham
13. Birthplace Poland
14. Maiden Name Golden
15. Birthplace Poland

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phil Rd & Bowley Lane
18 (a) Funeral director Jack Levin's Inc
(b) Address 1439 E. Baltimore St

19 JAN 25 1944 (Date rec'd by registrar) (b) Huntington or Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24-44 19 at 2.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1936 to Jan 24 1944 and that I last saw h. alive on Jan 24 1944

Immediate cause of death Hemorrhage into Cerebrum — Duration 1936

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron L. Solomon
Address 134 S. Bway Date signed 1/25/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B Registered No. G 13305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 PATAPSCO ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 PATAPSCO ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY PALM.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-5452

4. Sex: FEM. | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1877

8. AGE: Years 66 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace GERMANY. (Town, county, and state)

10. Usual Occupation OPERATOR

11. Industry or business ERLANGER. Co

FATHER 12. Name JOHN PALM.
13. Birthplace GERMANY.

MOTHER 14. Maiden Name MAGDALEN SPAMOL
15. Birthplace GERMANY.

16 (a) Informant CHARLOTTE PALM.
(b) Address 1712 PATAPSCO. ST.

17 (a) BURIAL. (Burial, cremation, or removal) (b) Date thereof JAN-26-44 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A A Co

18 (a) Funeral director Bernard C Harle
(b) Address 121 E Hoed St

JAN 25 1944 (Date rec'd by registrar) [illegible] Williams M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 23 1944 at 530 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1943 to Jan 23 1944 and that I last saw h[illegible] alive on Jan 23 1944.

Immediate cause of death: Acute dilation of heart — Duration 2 hr.

Due to: Mitral regurgitation — Duration 2 yr.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. L. Campbell M. D.
Address 1644 Hanover St Date signed 1/24/44

correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G 13306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132a

Registered No. G 13306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 E. Oliver St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 E. Oliver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Ruckle

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife Margaret M.
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Aug 10 - 1871

8. AGE: Years	Months	Days	If less than one day
72	5	12.	hr. min.

9. Birthplace Phila Pa.
(Town, county, and state)
10. Usual Occupation Engineer (Retired)
11. Industry or business P R R

FATHER
12. Name Wm Ruckle
13. Birthplace Phila Pa.

MOTHER
14. Maiden Name Estell Ball
15. Birthplace Phila Pa.

16 (a) Informant Mrs Margaret M Ruckle
(b) Address 1732 E Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E North Ave

18 (a) Funeral director Mendell E Humphreys
(b) Address 14-01 N. Broadway

19 JAN 25 1944 Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 19 44 at 1230 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 2 19 44 to January 22 19 44 and that I last saw deceased alive on January 21 19 44

Immediate cause of death
Myocardial Insufficiency — Duration 1 year
Due to Arteriosclerosis — 2 years
Due to
Other Conditions Lobar Pneumonia — 2 days
and Dehydration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert E Isenberg M. D.
Address 1005 E North Ave Date signed 1/25/44

(over)

correct age is especially important. If unknown, approximate; if over one hundred years, write the number clearly and legibly.

G 13307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

G 13307
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Middle Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Moncrey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Q. A. Co. Md. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace "

MOTHER
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant Mrs. Annie Fouldes
(b) Address 890 Pinder Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-26-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Grundy
(b) Address 878 W. Fairmount Ave.

19 (a) JAN 25 1944 (Date rec'd by Registrar) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1944, at 9:00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerosis cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratzer M.D. Medical Examiner.
Date signed January 24 1944

VS 151

G 13308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Clearview Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7705 Chestnut Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA E. ELGERT

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Widowed

6 (b) Name of husband or wife John W. Elgert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 1868

8. AGE: Years	Months	Days	If less than one day
75	10		hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Happel
13. Birthplace Unknown

MOTHER
14. Maiden Name Augusta Schmidt
15. Birthplace Germany

16 (a) Informant Mrs. Daur
(b) Address 2900 Clearview Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Leonhardt Funeral Home
(b) Address 7401 Belair Road
JAN 25 1944 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23rd, 1944 at 7:10 P

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1943 to Jan. 23 1944, and that I last saw her alive on Jan. 22 1944.

Immediate cause of death Chronic myocarditis
Chr. interstitial nephritis
Due to
Due to
Other Conditions Influenza
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration
Dec. 28
Jan. 4

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. M. Bacon M. D.
Address 2810 Taylor Ave Date signed 1/24/44

Correct age is especially important — any error, please report at once to Bureau of Vital Statistics, City Hall, Baltimore, Md.

G 13309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 13309 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 Light St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Strasser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Married

6 (b) Name of husband or wife Elsie B
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1890

8. AGE: Years	Months	Days	If less than one day
53	7	14	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Fredrick Strasser
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Gaertner
15. Birthplace Germany

16 (a) Informant Mrs Elsie B Strasser
(b) Address 922 Light

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md

18 (a) Funeral director William M Mareck
(b) Address 715 Lightfoot St Williamsport, Md

19 (a) 1-25-1944 (Date received by registrar) (b) — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1944, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20/44 to Jan. 23/44, and that I last saw him alive on Jan. 22/44.

Immediate cause of death	Duration
Chronic Cardiac Dilitation	Unknown
Due to	
Due to Fatty degeneration of heart	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Wade Chenoweth M. D.
Address 933 Hanover Date signed Jan. 24/44.

Copies are to especially requested.

#41 2-713310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13310

Registered No. 33B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 76 Wheeling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Lee Jacobs

3 (b) If veteran of what war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-42

8. AGE: Years	Months	Days	If less than one day
1	6	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Miss
11. Industry or business

MOTHER / FATHER
12. Name John E. Jacobs
13. Birthplace Maryland
14. Maiden Name Alberta Swift
15. Birthplace Maryland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director William M Marsch
(b) Address 715 Light St

19 (a) 2-5-1944 (Date received by registrar) (b) Livingston Williams M.D. (Signature of registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24-1944 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1944 to Jan. 24 1944 and that I last saw h[illegible] alive on Jan 24 1944

Immediate cause of death
Asphyxia
Due to Purulent Meningitis
Due to Influenza Rubella
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L Kaye M.D.
Address JHH Date signed 1-24-44

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13 a

G 13311 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Fawn Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Libero (Casamassa) Casamassa

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

?

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5325 Harford Road

19 JAN 25 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23-1944, at 9:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to

Other Conditions Hyperthrophy & dilatation of Heart
Chronic Nephritis: Arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malden M.D.
Medical Examiner
Date signed 1-24-44

13312

JL - 85959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2550 Garrett Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Loretta Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1889

8. AGE: Years 54 59 | Months 3 | Days 18 | If less than one day: hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Edgar S. Adams
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Ethel Hedpeth
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-44 (month) (day) (year)
(c) Cemetery or crematory Pinewood
Location Balto

18 (a) Funeral director Leonard J. Hunt
(b) Address 5305 Harford Rd

18 (c) JAN 25 1944 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23/ 1944 at 505A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1944 to 1/23 1944, and that I last saw h[illegible] alive on 1/23 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration 2 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide. X
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mattina M. D.
Address B. C. H. Date signed 1/24/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56a

G 13313

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elcy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	black	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-02

8. AGE: Years	Months	Days	If less than one day
42 41	-	21	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation housework
11. Industry or business

FATHER
12. Name Aaron Ellis
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Phillips
15. Birthplace Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O Wilson
(b) Address Lemmon & Williams

19 (a) (b) Registrar

Registered by register

JAN 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 22 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1943 to 1-22 1944, and that I last saw her alive on 1-22 1944.

Immediate cause of death: Peritonitis, post-operative — Duration 2 mos

Due to: Salpingo-oophoro-cystectomy, bilateral

Due to: Cystadenomas of ovary, bilateral — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-26-44

Major findings of operations: cystadenomas of ovary, bilat, peritonitis chronic

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bunch M. D.
Address Johns Hopkins Hosp Date signed 1-23-44

G 133134 — G 133134

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 92 C

File 83782

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Savoy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1881

8. AGE: Years 62 | Months 7 | Days 18 | If less than one day hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Lewis Savoy
13. Birthplace Md.

MOTHER
14. Maiden Name Mattie Deal
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27th/44 (Month) (day) (year)
(c) Cemetery or crematory Mt Zion Cemetary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bramble

19 (a) Registered JAN 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1944, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1943 to 1/23 1944 and that I last saw him alive on 1/23 1944.

Immediate cause of death Coronary Occlusion

Due to Chronic C.V.D. & aortic stenosis

Due to

Other Conditions Syphilis; Gen. arteriosclerosis (Include pregnancy within 3 months of death)

Duration 2-3 mo. 2 yrs.

Date of operation

Major findings of operation:

of autopsy: as above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. L. Sergman M.D.
Address BCH Date signed 1/24/44

PHYSICIAN
Underline the cause to which death should be charged statistically

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57E

Registered No. G 13315

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Joseph Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 236 S. Ann Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

V

3 (a) FULL NAME Mrs. Cecelia Rembis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Christ Rembis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 1899

8. AGE: Years	Months	Days	If less than one day
44	2	-	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

MOTHER / FATHER
12. Name Anthony Milwicz
13. Birthplace Poland
14. Maiden Name Mary Ogler
15. Birthplace Poland

16 (a) Informant Mrs Mary Rembis
(b) Address 236 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 404 S. Chester Street

JAN 25 1944 (Date received by Registrar) (b) Livingston Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22, 1944 at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1943 to Jan 22 1944, and that I last saw her alive on Jan 21 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to Pelvic Pelvic Cancer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan 19, 1944

Major findings of operation: Four Large abdominal cysts.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Christian J. Becker M. D.
Address St. Joseph's Hosp. Date signed 1/22/44

G 13316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 744

G 13316

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Woodbourne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 x 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Woodbourne Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME MABEL I. McNABB

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Samuel W.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4, 1886

8. AGE: Years	Months	Days	If less than one day
57	10	19	hr. ..... min. .....

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Amos Y. Reeder
13. Birthplace Phila., Pa.

MOTHER
14. Maiden Name Ella J. Coleman
15. Birthplace Ky.

16 (a) Informant Mrs. Warren Keller
(b) Address 907 Woodbourne Ave. 12

17 (a) Burial (b) Date thereof 1/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 25 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 19 44 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1943 to Jan. 23 1944, and that I last saw her alive on Jan. 23 1944.

Immediate cause of death Monocytic Leukemia — Duration Sept 1943

Due to .....

Due to .....

Other Conditions Arthritis

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature Earl H. Benson, M.D.
Address 5111 York Rd Date January 25, 1944
M. D.

G 13317 G 13317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4208 Ridgewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 27 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Ridgewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fanny Reading

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Reading

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Oct 7/1860

8. AGE: Years 83 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation
11. Industry or business at home

FATHER
12. Name B Samuel Lewis
13. Birthplace New York

MOTHER
14. Maiden Name Martha Pennington
15. Birthplace Delaware

16 (a) Informant Henrietta Larash
(b) Address 4208 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 27/1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry A. Arnwood
(b) Address 4204 Ridgewood Ave

JAN 25 1944 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1944 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1943 to 1/24 1944. and that I last saw h[illegible] alive on 1/24 1944.

Immediate cause of death: Duration
(a) Pulmonary tuberculosis = 12/8/1943
Cardiac arrhythmia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugo Carvelli, M. D.
Address 3902 Gaeland Ave Date signed 1-24-44

VS 180

G 13318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G 13318 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 Gwynn Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Righter

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-23-44

8. AGE: Years	Months	Days	If less than one day
—	—	1	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alfred Righter
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Myrtle Morris
15. Birthplace Maryland

16 (a) Informant Alfred Righter
(b) Address 319 Gwynn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director George L. Schwab
(b) Address 710 Frederick Ave

19 (a) (Date received by registrar) (b) [illegible] Registrar

JAN 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1944 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1944 to 1-24 1944 and that I last saw h[illegible] alive on 1-24 1944

Immediate cause of death Congenital Stenosis of Biliary Tree — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] J. Bryan M. D.

Address Agnes Hospital Date signed 1/25/44

G 13319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 13319 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3003 Arunah ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Arunah ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeanette Watson

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John J Watson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 3, 1867

8. AGE: Years 76 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Crisfield, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Walter
13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Dickerman
15. Birthplace Md

16 (a) Informant Irving Watson
(b) Address 4007 Woodrige Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Balto., Md.

18 (a) Funeral director A. F. Eyerand Bros.
(b) Address 1400 N. Charles St.

JAN 25 1944 (Date received by registrar) (b) Registrar

VS 180.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1944, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944 to Jan 23 1944; and that I last saw her alive on Jan 23, 1944

Immediate cause of death: Cardiac thrombosis — Duration 2 days

Due to Senile Myocarditis — 1 yr

Due to Cerebral Sclerosis — 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Hamilton Williams, M.D.
Address 18 Rudolph St. Date signed Jan 25 1944

Hamilton Williams, M.D.

G 13320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G 13320
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1211 Riverside Ave
(b) Street address Baltimore, Maryland
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Riverside Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A HARTLOVE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John W. Hartlove (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 16, 1846

8. AGE: Years	Months	Days	If less than one day
97	10	9	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name ? Wright
13. Birthplace Md.

MOTHER
14. Maiden Name Don't Know
15. Birthplace Md.

16 (a) Informant Mrs. Frances Caswell
(b) Address 1211 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Oakland Cem.
Location Essex, Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Chase St. Balto. 30, Md.

19 (a) (Date received by Registrar) (b) Livingston Williams M.D. (Registrar)

AN VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 19 44 at 10 A.M.

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Williamson M.D.
Medical Examiner.
Date signed 1-25-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77 D

Registered No. G 13321

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 344 Mason Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SHIRLEY A ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josie M. Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22nd 1903

8. AGE: Years	Months	Days	If less than one day
40	7	3	hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business Fairfield Ship Yards

FATHER
12. Name W. H. Adams
13. Birthplace W. Va

MOTHER
14. Maiden Name M. L. Godfrey
15. Birthplace W. Va.

16 (a) Informant Josie M. Adams
(b) Address 344 Mason Court

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/26/44 (month) (day) (year)
(c) Cemetery or crematory Ivydale
Location W. Va.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 JAN 26 1944 (Received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1944 at 4:46 P.M.

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 1/25/44

G 13322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G 13322 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2058 E. Hoffman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2058 E. Hoffman Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaretta Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Mulatto	Widowed

6 (b) Name of husband Joshua Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7th 1870

8. AGE: Years	Months	Days	If less than one day
73	8	18	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name — Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Mrs Mary E. De Moss
(b) Address 708 E. 41st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 Eutaw Place Baltimore, Md.

JAN 26 1944 (Date rec'd by registrar) (b) Thurlington Tolliaferro, M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25-1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulderig M.D. Medical Examiner.
Date signed 1-25-44

Correct age is especially important. If uncertain, please write the causes of death clearly and legibly.

13323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 13323
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Mc Mechen St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Vizcarro

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13, 1944

8. AGE: Years	Months	Days	If less than one day
0	0	12	hr. min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Vizcarro
13. Birthplace Utica N. Y.

MOTHER
14. Maiden Name Kathryn Klein
15. Birthplace Washington D. C.

16 (a) Informant Mrs. John Vizcarro
(b) Address 112 Mc Mechen St

17 (a) Burial (b) Date thereof 1/26/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Wilkens Cook Inc
(b) Address 217 E. Saint Paul St.

19 (a) Filed JAN 26 1944 Wilmington Williams, Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24, 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13, 1944, to Jan 24 1944, and that I last saw her alive on Jan 24 1944.

Immediate cause of death	Duration
Resp. Failure	
Due to Dehydration, Acidosis	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Robert B. Fenning M. D.
Address Mercy Hosp Date signed 1/24/44

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

13324

YA-86129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G 13324

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3515 E. Lombard St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1880

8. AGE: Years	Months	Days	If less than one day
63	5	3614	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Samuel Hopkins (d)

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Carrigan

15. Birthplace Ireland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Balto Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) JAN 26 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1944 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1944 to 1/24 1944 and that I last saw ~~him~~ alive on 1/24 1944

Immediate cause of death Strep. septicemia; cardiac failure. — Duration 3 hd.

Due to Strep. abscess of neck; A SCVD — 2 mo.

Due to

Other Conditions Old TBC, inact; left bronchopneumonia (Include pregnancy within 3 months of death) — 7 yr.

Date of operation

Major findings of operation:

of autopsy: Ass absent

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Jayman M. D.

Address 13 CH Date signed 1/24

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 13325 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 Hollen Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Hollen Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Shaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, ~~widowed or~~ divorced: Married

6 (b) Name of ~~husband or~~ wife Anna E. Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6th 1878

8. AGE: Years 65 | Months 2 | Days 18 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Acct Clerk

11. Industry or business State Rds Commission

FATHER
12. Name John W. Shaw
13. Birthplace Md

MOTHER
14. Maiden Name Sidney L. Lamy
15. Birthplace Md.

16 (a) Informant Mrs Anna Shaw
(b) Address 609 Hollen Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Balto. Co. Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul St

19 (a) JAN 26 1944 (b) Huntington Williamson, M.D.
(Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24th 1944 2:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15th 1941 to Jan. 24th 1944 and that I last saw h[illegible] alive on Jan 24th 1944.

Immediate cause of death	Duration
Hypertensive Cardio-vascular-renal disease	5 yrs.
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work? None
(Specify type of place)
(e) Means of injury None

23. Signature A. S. Chalfant M.D.
Address 6210 York Rd Date signed Jan 25, 44

Correct age is extremely important. Physician: please write the cause of death clearly and legibly.

G 13326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

Registered No. G 13326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2548 W Fayette St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Marney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Minnie Marney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24 1904

8. AGE: Years	Months	Days	If less than one day
39	10	3	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business Balto. Transit Co.

FATHER
12. Name Thos. Marney
13. Birthplace England

MOTHER
14. Maiden Name Jennie Davidson
15. Birthplace England

16 (a) Informant Minnie Marney
(b) Address 2548 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balt. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St Huntington Williams, Registrar

19 (a) Date received (b)
JAN 26 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1944, at 2 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on Jan 24 19 1944

Immediate cause of death Congestive heart failure — Duration

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. P. Guyther M.D.
Address Mercy Hosp. Date signed 1/26/44

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

13327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible]
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Alfred Aiken

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
About 85			hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Thomas Aiken
13. Birthplace Holland

MOTHER
14. Maiden Name Cecelia [illegible]
15. Birthplace Ireland

16 (a) Informant Rev Tatary
(b) Address 1702 South Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1247 St. Paul St.

19. (a) JAN 26 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1944, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1944, to 1-24 1944, and that I last saw him alive on 1-24 1944.

Immediate cause of death [illegible] — Duration 2 hr

Due to [illegible] — 7 hrs.

Due to [illegible]

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Clemens Harlitz M. D.
Address [illegible] Date signed 1/24/44

13328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 13328

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 Brevard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Brevard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina Downey

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4 Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 182

8. AGE: Years 7 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name John H. Manns

13. Birthplace Baltimore Co. Md.

MOTHER 14. Maiden Name Louisa Manns

15. Birthplace Balto. Co. Md.

16 (a) Informant Cora Lee

(b) Address 906 Brevard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Anne Arundel Co. Md

18 (a) Funeral director Mrs. Geo. H. Holland

(b) Address 1631 Druid Hill Ave

JAN 26 1944 for Wilmington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1944, at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to 1/20 1944, and that I last saw h alive on Jan 20 1944.

Immediate cause of death: Lobar Pneumonia

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. N. Hetelson

Address 1 Y 25 Lee Ave Date signed 1/24/44 M. D.

13329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 13329
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2345 W.Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2345 W.Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W.Williams,

3 (b) If veteran, name war ---

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Irene E.Williams,
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) October 24 1880

8. AGE: Years 63 | Months 3 | Days - | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Bureau Receipts

11. Industry or business Baltimore,City

FATHER
12. Name Jonathan E.Williams
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Irene E.Williams.
(b) Address 2345 W.Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan.27.1944 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Howard Co.Md.

18 (a) Funeral director Robert S.Little,
(b) Address 2700 Edmondson Ave.

JAN 26 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 24 1944 at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1943 to Jan 24 1944, and that I last saw h[illegible] alive on Jan 23 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 7 hrs
Due to: Cerebral Hemorrhage — 2 yrs 6 mos
Due to: Hysteria Sclerosis — 4 yrs
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G.W.Bellamy M. D.
Address 224 W. North Ave Date signed 1/28/44

13330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 13330
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Brunswick St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Brunswick St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME John A. Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Johanna E. Miller
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 4 1889

8. AGE: Years	Months	Days	If less than one day
60	8	20	— hr. — min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry J. Miller
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name —
15. Birthplace Baltimore, Md

16 (a) Informant Johanna E. Miller
(b) Address 511 Brunswick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md

18 (a) Funeral director F. D. WIPPERT. SON
(b) Address 1800 N. Baltimore St

JAN 26 1944 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24th 1944 at 5-0 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1943, to Jan 24 1944 and that I last saw him alive on Jan 21 1944

Immediate cause of death Cerebral Hemorrhage — Duration 6 days
Due to Arteriosclerosis Cardio-Vascular Renal disease — 1 year
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Albert Kerpowicz M. D.
Address 1934 Wilkens Ave Date signed 1/27/44

VS 180

Please write the causes of death clearly and legibly.

G 13331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 13331

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 W 27th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 W 27th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alverta Reeves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife Wyndus M. Reeves

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1873

8. AGE: Years	Months	Days	If less than one day
70	9	12	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

MOTHER / FATHER

12. Name Richard Price

13. Birthplace Germany.

14. Maiden Name Margaret Face

15. Birthplace Pa.

16 (a) Informant Lottie N. Sawyer.

(b) Address 221 W 27th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26/44 (month) (day) (year)

(c) Cemetery or crematory Govans Presbyterian

Location Bellona Ave.

18 (a) Funeral director Thanowetz & Donovan

(b) Address 3615-17 Edmondson Ave

JAN 26 1944 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 1944, at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1942 to Jan 24 1944 and that I last saw h e alive on Jan 24 1944.

Immediate cause of death	Duration
Myocardial Insufficiency	2 Wks
Due to Cardio-renal-Vascular Disease and	3 yrs
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J N Nelson M. D.

Address 617 N. 40 St Date signed 1/26/44

VS 180

3332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G 13332 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 N Brice st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N Brice st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm H Stafford

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 8 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	9	18	16	

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John H Stafford
13. Birthplace Md

MOTHER
14. Maiden name Madora Levatt
15. Birthplace Md

16 (a) Informant Mrs Annie Stafford
(b) Address 613 N Brice st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Joseph A Farley
(b) Address Fulton & Fayette

19 (a) JAN 26 1944 Huntington Williams M.D. REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to Jan 23 1944 and that I last saw him alive on Jan 23 1944.

Immediate cause of death	Duration
Chronic Myocarditis c	2 yrs
Antecedent Hypertension c	
Due to Acute Heart Failure	3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Arlman M.D.
Address 821 W North Ave Date signed 1/25/44

VS 150

13333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G 13333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Catonsville Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md (b) County Catonsville
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Mary's Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Vaughan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24 1883

8. AGE: Years	Months	Days	If less than one day
60	3	1	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Utility man
11. Industry or business Gas & Elec. Co.

FATHER
12. Name Samuel (dec'd)
13. Birthplace

MOTHER
14. Maiden Name Linda Speem
15. Birthplace Maryland

16 (a) Informant Mrs Emma Vaughan
(b) Address St Marys St Catons

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Randallstown Md

18 (a) Funeral director George G Fahey
(b) Address Fulton & Fayette

19 (a) Filed (Registrar) (b) Huntington Williamsport Md

JAN 26 1944

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1944 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1944 to 1/25 1944, and that I last saw him alive on 1/25 1944.

Immediate cause of death	Duration
Carcinoma of the Gall Bladder with	
Due to metastases	6 mos?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1/18/44

Major findings of operation: Carcinoma of Gall Bladder with met.

Autopsy: "

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Vaughan M.D.
Address St Agnes Hosp Date signed 1/27/44

M. D. B. 1939-9

13334 HEALTH DEPARTMENT—CITY OF BALTIMORE G 13334

CERTIFICATE OF DEATH

1. PLACE OF DEATH The Garrison Nursing Home

Registered No.

CITY OF BALTIMORE: (No. 2803 Garrison Blvd. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. 3 mos. dy. How long in U. S. If of foreign birth? yrs. mos. dy.

2. FULL NAME Katherine M. Roddy

(a) Residence: No. St. Anthony, Md. St., Ward. Frederick Co.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel F. Roddy

6. DATE OF BIRTH (month, day, year) 2-12-1872

7. AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	71	11	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. NONE

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) ?

FATHER

13. NAME Joseph White

14. BIRTHPLACE (city or town) (State or country) N.Y.

MOTHER

15. MAIDEN NAME Mary A. Marken

16. BIRTHPLACE (city or town) (State or country) Frederick Md.

17. INFORMANT Archie White

(Address) 155 Burnside Ave., E. Hartford, Conn.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. St. Marys Cem. Emmitsburg, Md. Date Jan. 28, 1944

19. UNDERTAKER M. L. Creager & Son.

(Address) Thurmont, Md.

20. Filed JAN 26 1944 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan. 25, 1944

22. I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1943 to January 25, 1944

I last saw her alive on January 24, 1944 Death is said to have occurred on the date stated above, at 7 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	1 Mo.

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Edward G. Jones Jr. M. D.

(Address) 216 E. Church St. Frederick

Instructions on back of certificate.

3335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 166

G 13335 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 646 N. Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: AUGUSTUS M. ASH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1927

8. AGE: Years 17 | Months | Days 9 | If less than one day hr. min.

9. Birthplace Providence, Rhode Island
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Ash
13. Birthplace Va.

MOTHER
14. Maiden Name Virgie Goodman
15. Birthplace Va.

16 (a) Informant Virgie Goodman Ash
(b) Address Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-44 (month) (day) (year)
(c) Cemetery or crematory Newport News
Location Va

18 (a) Funeral director Sam'l H. Chase & Son
(b) Address 638 N. Gilmore

JAN 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 1944, at 10:15 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of neck.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-24-44 at P. M.
(b) Where did injury occur? Mullikin & Bond Streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Revolver shot during altercation.

23. Signature H. K. Wollenmeber M.D.
Medical Examiner.
Date signed 1-25-44

G 13336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

T.N 84193

13B

G 13336 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 months
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Kensler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charlotte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug, 15, 1895

8. AGE: Years 48 | Months 5 | Days 7 6 | If less than one day hr. min.

9. Birthplace S. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Kensler
13. Birthplace 1715 W. Franklin St

MOTHER
14. Maiden Name Carrie Williams
15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave / Records

17 (a) Burial (b) Date thereof Jan. 26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

JAN 26 1944 (b) Huntington Williams, M.D.
(Date filed) (Signature) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21 1944, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1943 to 1/21 1944, and that I last saw h[illegible] alive on 1/21 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Do above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mattner M.D.

Address B.O.H. Date signed 1/24/44

Correct age is especially important. If uncertain, please write the causes of death clearly and legibly.

G 13337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G 13337

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Hollins St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William A Murphy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carrie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3/24/1897

8. AGE: Years	Months	Days	If less than one day
47	10	28	hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business Glass House

FATHER
12. Name William Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mgt Hunt
15. Birthplace Ireland

16 (a) Informant Carrie A Murphy
(b) Address 1927 Hollins St

17 (a) Burial (b) Date thereof 1/27/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Frederick Rd

18 (a) Funeral director Edward Loudenslager
(b) Address 1359 Wilkens Blvd

19 (a) JAN 26 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VR 161

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1944, at 5:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd & 3rd degree burns

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/3

(a) Date of injury January 8, 1944 6:15 A M.
(b) Where did injury occur? Maryland Glass Co
(c) Did injury occur at home, on farm, industrial place, in public place Industrial Place While at work Yes
(d) Means of injury Clothes caught fire

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed January 24, 1944

G 13338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 13338 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Robert Lembach

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	4	10	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Milton W. Lembach
13. Birthplace Maryland

MOTHER
14. Maiden Name Beulah Ryley
15. Birthplace Md

16 (a) Informant Milton W. Lembach
(b) Address 2324 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Harford Rd.

18 (a) Funeral director Edward Toulson
(b) Address 2359 Wash. Blvd.

19 JAN 26 1944 (Date rec'd by Registrar) (b) Huntington Williams Inc. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Interstitial Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraham M.D.
Medical Examiner.
Date signed Jan 25 1944

VS 161

13339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 13339
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 North Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 North Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Patricia Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1943

8. AGE: Years	Months	Days	If less than one day
	8	11	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Curtis
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Gladys Bodley
15. Birthplace Baltimore Maryland

16 (a) Informant Mary Curtis
(b) Address 232 North Gilmor Street

17 (a) Burial (b) Date thereof Jan 26, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Baltimore County

18 (a) Funeral director Joseph A. Busby
(b) Address 409 North Mount Street

JAN 26 1944 Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1944 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1944 to Jan 22 1944 and that I last saw him alive on Jan 16 1944.

Immediate cause of death
(a) Broncho Pneumonia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
6 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. N. Hatcher M.D.
Address 1225 Eutaw Pl Date signed 1/26/44

VS 180

correct age is especially important. Physician: please write the cause of death clearly and legibly.

13340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G 13340
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 E Mulberry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 E Mulberry St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mattie Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edgar Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 26, 1914

8. AGE: Years 39 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Farmville Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sam Harvey
13. Birthplace Va

MOTHER
14. Maiden Name Hannah Faith
15. Birthplace Va

16 (a) Informant Edgar Howard
(b) Address 113 E Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28, 1944 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary
Location Anne Arundel County

18 (a) Funeral director Joseph A. Sealy
(b) Address 409 N Howard Street

19 (a) JAN 26 1944 (Date rec'd by registrar) (b) Huntington Maryland, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1944, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Jan 24 1944, and that I last saw h-- alive on Jan 24 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 1 hr 44

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peter F. Calvert M. D.
Address 522 N Bond Date signed 1/26/44

VS 8

246950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30B

G 13341

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 N Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Otis A. Worthington

3 (b) If veteran, name war none

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anne M.

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 8-7-75

8. AGE: Years 68 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Howard Co. Md (Town, county, and state)

10. Usual Occupation Police

11. Industry or business Bethlehem Steel Co.

MOTHER / FATHER

12. Name Otis Worthington

13. Birthplace Md

MOTHER

14. Maiden Name Nellie Dorsey

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location Balto. Md.

18 (a) Funeral director Wm. J. Tichenor

(b) Address Balto. Md.

JAN 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1944 at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1943 to Jan 25 1944 and that I last saw him alive on Jan 25 1944.

Immediate cause of death Terminal bronchopneumonia. — Duration 1 wk

Due to General debilitation due to general paresis — Duration months

Due to Tertiary Syphilis

Other Conditions Rheumatoid arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Worthington M.D.

Address Johns Hopkins Hosp Date signed 1/28/44

VS 150

13342 ✓ G 13342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Roslyn Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT PARKER SNOW

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Nellie Agle Snow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1868

8. AGE: Years	Months	Days	If less than one day
75	1	12	hr. min.

9. Birthplace Baltimore, Md. Baltimore Co
(Town, county, and state)

10. Usual Occupation Painter & Decorator

11. Industry or business Self

FATHER 12. Name William Snow
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Anna Conrad.
15. Birthplace Baltimore, Md

16 (a) Informant Victory Hurt
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 26 1944 (Date received by registrar) Huntington Williams, M.D. (Signature of registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1944, at 11.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944 to Jan 24 1944, and that I last saw him alive on Jan 24 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Pleural Effusion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Van Lill M. D.
Address Union Memorial Hosp Date signed 1-25-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ G 13343 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1934 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOUGLAS DENNIS RAYMO

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-01-7256

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy Mary Raymo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1886

8. AGE: Years 57 Months 8 Days 3 If less than one day hr. min.

9. Birthplace Masenna, N. Y.
(Town, county, and state)

10. Usual Occupation Engineer - Construction

11. Industry or business Davison Chemical Co.

FATHER
12. Name Huey Raymo
13. Birthplace N. Y.

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Daisy M. Raymo
(b) Address 1934 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)
(c) Cemetery or crematory Mountain View Cem.
Location Union Bridge, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 26 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1944 at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1943 to 1-24-1944 and that I last saw him alive on 1-24-1944.

Immediate cause of death: Chronic myocarditis — Duration: Unknown

Due to: Unknown

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo B. Dufort M. D.
Address 2802 Harford Date signed 1-26-44

VS 160

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13344 ✓ G 13344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 W. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 W. Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAJOR WILLIAM E. HOKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	214-20-8885

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret G. Hoke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1865

8. AGE: Years	Months	Days	If less than one day
78	2	29	hr. min.

9. Birthplace Memphis, Scotland Co., Miss.
(Town, county, and state)
10. Usual Occupation Retired Consulting Engineer
11. Industry or business Self

FATHER
12. Name Joseph Wilson Hoke
13. Birthplace Chambersburg, Pa.

MOTHER
14. Maiden Name Elizabeth Storer
15. Birthplace Carlinsville, Ill.

16 (a) Informant Mrs. Margaret G. Hoke
(b) Address 1405 W. Cold Spring Lane

17 (a) Removal (b) Date thereof 1/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington National Cem.
Location Arlington, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 26 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25, 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1944, to Jan 25 1944, and that I last saw him alive on Jan 25 1944.

Immediate cause of death

(1) Cerebral hemorrhage — Duration

Due to (2) hypertension-arteriosclerosis

Due to

Other Conditions none.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles S. Nesbitt M. D.
Address 1730 Linden Ave Date signed Jan 27

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 13345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G 12845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St Rutland Ave
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 7 14
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N B'way Jones (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 46 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Selig Wulfe
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Robert Taylor
(b) Address 900 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-44 (month) (day) (year)
(c) Cemetery or crematory Orel Hayden
Location Hebrew Friendship Sec

18 (a) Funeral director Isaac Harris Inc
(b) Address 1439 E. Balto St

19 (c) JAN 26 1944 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1944, at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1944 to 1/25 1944, and that I last saw h alive on 1/25 1944.

Immediate cause of death Cerebral embolism

Due to Mitral stenosis

Due to

Other Conditions Rheumatic Carditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Murray J Steinberg
Address Provident Hospital Date signed 1/25/44

VS 180

correct age is especially important. Typewriter preferred; write ink. Use chart of death clearly and legibly.

C 13346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C-42846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere + Greenspring Aves
(c) Hospital or institution:
Hebrew Home for Aged + Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere + Greenspring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Schwartz

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Zeley Schwartz
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine
15. Birthplace Germany

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd + Hampton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 JAN 26 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1944 at 2:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1944 to Jan 25 1944, and that I last saw him alive on Jan 24 1944.

Immediate cause of death: Chr. card. vascular disease
Arteriosclerosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Levin

Address 3400 Kelton Rd Date signed 1/25/44 M. D.

VS 150

correct age is especially important. Physicians, undertakers, please write the names of cities and counties in full.

G 13347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G 13347
Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 3524 Pk. Hgts. Ave
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Pk. Hgts. Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mollie Brodel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15-1860

8. AGE: Years	Months	Days	If less than one day
93	6	10	11 hr. 15 min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Aaron Mayer
13. Birthplace Russia

MOTHER
14. Maiden Name Abana
15. Birthplace Russia

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-44 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem.
Location Wash. Blvd.

18 (a) Funeral director Jacob Levin Inc
(b) Address 1428 E. Balto. St

19 JAN 26 1944 (Date received by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25-44 19 , at 11 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-40 to 1-25-44, and that I last saw her alive on 1-25-44.

Immediate cause of death Myocarditis decompensating — Duration 2 yrs

Due to hypertension

Due to arteriosclerosis

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Lotsoff M. D.
Address Reisterstown Md. Date signed 1-20-44

VS 3

G 13348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G 13348

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 S. Charles (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Catherine Sortino Sortino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Joseph Sortino

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2 1914

8. AGE: Years 29 | Months 5 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John B. Sparenberg
13. Birthplace Md.

MOTHER
14. Maiden Name Mamie Nubert
15. Birthplace Md.

16 (a) Informant Joseph Sortino (Husband)
(b) Address 1514 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28/41 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederik Rd. Balt. Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

JAN 26 1944 (Date received by local registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1944 at 2 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to Jan 25 1944 and that I last saw her alive on Jan 25th 1944

Immediate cause of death Congestive heart failure — Duration

Due to Rheumatic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan M. D.

Address St Joseph's Hospital Date signed 1-25-44

Correct age is especially important. Physicians, please write one name of writer clearly and legibly.

13349

VA-82662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G 13349

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos. 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Penrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY Elizabeth Carr (Mary Elizabeth Carr)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Carroll Carr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1890

8. AGE: Years	Months	Days	If less than one day
53	10 11	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin Allen
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Baumann
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 1-28-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto., Md.

18 (a) Funeral director Bloyer & Flanagan
(b) Address 1426 Light St
(c) Huntington Williams, Mgr

JAN 26 1944
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1944, at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1943 to 1-25 1944, and that I last saw h-r alive on 1-25 1944.

Immediate cause of death Pulmonary Tuberculosis (a)

Due to (b)

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul A. Dettman M. D.

Address B. C. H. Date signed 1/25/44

G 13350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1920

Registered No. G 13350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2921 Clearview Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Clearview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Glaeser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Mary Glaeser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17-1858

8. AGE: Years	Months	Days	If less than one day hr.	min.
85	4	7		

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Artist

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Howard Glaeser
(b) Address 2921 Clearview Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt Lurmes
Location Balto Md

18 (a) Funeral director Leonard Hardy
(b) Address 2305 Harford Rd

19 JAN 26 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1944 to 1-25 1944 and that I last saw h alive on Jan 25 1944.

Immediate cause of death: Mitral Insufficiency — Duration: 5 yrs

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. J. Nurkin M. D.
Address 7101 Harford Rd Date signed

NURKIN

13351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 13351

Registered No. 13B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4703 Hampden Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 873 Dunkirk Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Andrew Ott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Mildred Ott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15 1873

8. AGE: Years	Months	Days	If less than one day
70	5	9	hr. min.

9. Birthplace Retired Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs Elizabeth Schmidt

(b) Address 873 Dunkirk Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26-44 (month) (day) (year)

(c) Cemetery or crematory Woodland Park

Location

18 (a) Funeral director Leonard Merz

Address 830 S Hanford St

19 (a) JAN 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1944 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1944 to Jan 24 1944. and that I last saw him alive on Jan 23 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions Chronic Myocarditis — 10 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature N. V. Harbold M.D.

Address 4706 Harford Road Date signed 1/25/44

VS 150

G 13352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G 13352 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address REDWOOD & GREENE STS.

(c) Hospital or institution: UNIVERSITY HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3118 Foster Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME AUGUST LOWENSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Emma C. Holzman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1874

8. AGE: Years	Months	Days	If less than one day
69	9	19	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Washer

11. Industry or business Monitor Building

FATHER 12. Name August Lowensen

13. Birthplace Germany

MOTHER 14. Maiden Name Seibert

15. Birthplace Baltimore Md,

16 (a) Informant Emma C. Lowensen

(b) Address 3118 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27, 1944 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway

19 (a) 1944 (b) [illegible] registrar for Huntington Williams, M.D. Registrar

JAN 26

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 23, 1944, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 16, 1944, to JAN. 23, 1944, and that I last saw him alive on JAN. 23, 1944.

Immediate cause of death	Duration
MASSIVE PULMONARY EMBOLISM	
Due to RIGHT HERNIOPLASTY — OPERATIVE SITE	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation JAN. 18, 1944

Major findings of operation: INDIRECT HERNIA - RIGHT SIDE

of autopsy: PULMONARY EMBOLUS

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William B. Hagan M. D.

Address Univ. Hosp. Date signed 1/25/44

G 13353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓61

G 13353 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Josephine Vittek
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Frank J. (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/72

8. AGE: Years	Months	Days	If less than one day
71	10 11	25	hr. min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert Pajer
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Mayme Vittek (daughter)
(b) Address 506 N. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

(b) Rec'd by registrar
Registrar

26 JAN 1944
VS 350

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1944 at 2.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1944 to Jan. 24 1944 and that I last saw him alive on Jan. 23 1944.

Immediate cause of death Cardio respiratory failure — Duration

Due to Lobar pneumonia, rt. lower lobe. — 10 days

Due to — ?

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Mungavinge Jr. M. D.
Address 332 E. Lanvale St. Date signed 1/24/44

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G 13354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 13354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2322 E. [illegible] St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORA LAPF (nee [illegible])

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife widow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/[illegible]

8. AGE: Years	Months	Days	If less than one day
84 yrs.	1	19	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant [illegible]
(b) Address 2322 E. [illegible] St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address 2601 E. [illegible] Ave.

19 (a) 1/26 1944 (Date received by registrar) (b) Livingston Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1944 to 1/23 1944, and that I last saw her alive on 1/21 1944.

Immediate cause of death
(a) Coronary thrombosis

Due to Hypertension & Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
1 wk
10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. B. Williams M.D.
Address 1901 E. Lexington St. Date signed 1/24/44

G 13355 / 889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13355 Registered No. / 117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE SIMMONS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
55 54			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name George Simmons
13. Birthplace Md

MOTHER
14. Maiden Name Rachel Jones
15. Birthplace Md.

16 (a) Informant Mary E. Cole
(b) Address 816 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)

(c) Cemetery or crematory Laurel Cemetery
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 1600 Druid Hill Ave
JAN 26 1944

19 (a) Huntington Williams, M.R. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25, 1944, at 2:10 A. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hemorrhage from gastric ulcer.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollammeber M.D.
Asst Medical Examiner.
Date signed 1-25-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G 13356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13356 Registered No. 30 C

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 Brune Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Brune St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. RINGGOLD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54 Y.			hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name ?
13. Birthplace .

MOTHER
14. Maiden Name ?
15. Birthplace .

16 (a) Informant Diaretta Blue
(b) Address 516 Brune St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) JAN 26 1944 (Date rec'd by registrar) (b) Investigator Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 19 44, at 4 30 M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilis, cerebrospinal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 1-25-44

G 13357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 13357 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 549 Oxford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ASIE AYRES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Wid

6 (b) Name of husband or wife Maude Ayres
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Buckingham Co. Va.
(Town, county, and state)
10. Usual Occupation Laundry
11. Industry or business Union Mend. Hosp.

FATHER
12. Name George W. Ayee
13. Birthplace Va

MOTHER
14. Maiden Name Martha Goines
15. Birthplace Va.

16 (a) Informant Mrs Maude Ayes
(b) Address 1803 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

JAN 26 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1944, at 5 45 P.M.

21. I certify that I took charge of the remains described above, held an inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. A. Wallenmeyer M.D.
Medical Examiner.
Date signed 1-25-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 13358
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 W. 33d
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Ellen Magruder

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Thomas G Magruder
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) May 5, 1874

8. AGE: Years	Months	Days	If less than one day
69	8	19	hr. min.

9. Birthplace Keyser, West Virginia (Town, county, and state)
10. Usual Occupation Practical nurse
11. Industry or business

FATHER
12. Name John Hesser HESSER
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mary Beans
15. Birthplace West Virginia

16 (a) Informant Helen V. Friedley
(b) Address 842 W 33d St, Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27-1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 1401 Falls Road

19 Filed JAN 26 1944 Huntington Williams, Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1944, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Jan 24 1944, and that I last saw her alive on Jan 24 1944.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Arteriosclerotic cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J Sam Lill III M. D.
Address Union Memorial Hosp Date signed 1-24-44

G 13359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 13359 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Severn Apts., Cathedral & Monuments Sts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Cathedral St. (Severn Apts.) (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mary Greenwood Smith Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife John D. Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1868

8. AGE: Years	Months	Days	If less than one day
75	9	26	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Benjamin F. Smith
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary Evans
15. Birthplace W. Va.

16 (a) Informant Dr. John E. Howard
(b) Address Lutherville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/44 (month) (day) (year)
(c) Cemetery Green Mount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1906 Eutaw Place

19 (a) 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1944, at 5.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1943, to Jan. 25 1944, and that I last saw her alive on Jan. 24 1944.

Immediate cause of death Coronary Occlusion — Duration 4 days
Due to Arterio-sclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wade H. Allen, M. D.
Address 6 E. Eager St. Date signed 1/26/44

Dr. Wade H. Allen

G 13360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G 13360 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 338 E 28th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr Charles T. Brown
3 (b) If veteran, name war NO
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Myrtle J. Brown
6 (c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) Jan 27. 1887
8. AGE: Years 56 Months 11 Days 29 If less than one day hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Motorman - Retired
11. Industry or business Balto Transit Co
FATHER 12. Name Edward P. Brown
13. Birthplace Va
MOTHER 14. Maiden Name Betty L. Richardson
15. Birthplace Va.
16 (a) Informant Myrtle J. Brown
(b) Address 338 E. 28th St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location
18 (a) Funeral director Mr. & Mrs. John W. Tenfelsdorf
(b) Address 801 W. Fayette St
19 (a) (Undertaker or other) (b) Huntington Williams, M.D.

JAN 26 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1944 at 1:50 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1944 to Jan 25 1944, and that I last saw him alive on Jan 24 1944.
Immediate cause of death Congestive heart failure
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Brennan M. D.
Address St Joseph's Hospital Date signed 1-25-44

G 13361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13361 / 939 Registered No.

YA

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Katherine Short

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1900?

8. AGE: Years 43 45 ? | Months ? 5 | Days ? 8 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Randolph Cromwell (d)
13. Birthplace Md.

MOTHER
14. Maiden Name Martha King
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Harlem Ave.

19 (a) Date received by registrar JAN 26 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1944, at 7 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1944, to 1-23 1944, and that I last saw h alive on 1-23 1944.

Immediate cause of death

Cardiac Decompensation — Duration ?

Due to Arteriosclerotic Heart Disease — Duration ?

Due to Cellulitis L thigh — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald Hoffa M. D.

Address Balto City Hosp Date signed 1-22-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G 13362 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County Scott
(c) City or town Gate City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hellum Edmonds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1864

8. AGE: Years 75 | Months 11 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Gate City, Virginia (Town, county, and state)

10. Usual Occupation Office work

11. Industry or business —

FATHER
12. Name Edmonds, Dr. Wm. J.
13. Birthplace Rodgersville, Tenn.

MOTHER
14. Maiden Name Hester Richmond
15. Birthplace Lee Co. Va.

16 (a) Informant Mrs. J. E. Kane
(b) Address Gate City, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/26/44 (month) (day) (year)

(c) Cemetery or crematory
Location Gate City, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1943 to Jan 25 1944, and that I last saw him alive on Jan 25 1944.

Immediate cause of death: Carcinoma of parotid — Duration: 1 yr.

Due to:

Due to:

Other Conditions: Secondary anemia cachexia.
(Include pregnancy within 3 months of death)

Date of operation Dec 12, 1943

Major findings of operation: Carcinoma of parotid

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isabella Hanneson M. D.
Address Church Home + Hospital Date signed 1-25-44

Correct age is especially important. Physicians, please write out causes of death clearly and legibly.

G 13363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13363 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Usual address 2438 Edmondson ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2438 Edmondson ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Eidenhower

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary W. Eidenhower

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Dec. 14-1866

8. AGE: Years 77 | Months 1 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Baldwin
15. Birthplace

16 (a) Informant Wm Mark Eidenhower
(b) Address 2438 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Roberts Bros
(b) Address 2244 Eutaw St.

19 (a) (Signature of local registrar) (b) Huntington Willard Registrar

JAN 28 1944

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25- 1944, at 4:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulder M.D. Medical Examiner.
Date signed 1-26-44

G 13364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G 13364 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.A. Mumac Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert E. Bell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Minnie Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18 1897

8. AGE: Years	Months	Days	If less than one day
46 45	8	4	hr. min.

9. Birthplace Newport News Va (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Hotel

FATHER
12. Name William T. Bell
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Carey
15. Birthplace Va

16 (a) Informant Minnie Bell (W)
(b) Address 1518 Brentwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1028 W. Montgomery St

JAN 26 1944 (Date registered) per Antigo Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1944, at 10:00 P.M.

21. I certify that I took charge of the remains described above, held an Enquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Lung Abscess
Massive Emphysema chest

Due to

Other Conditions Luetic Cardio-vascular disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dwight B. McNalley Medical Examiner.
Date signed 1/24/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 777

G 13365 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 N. High Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EARNEST C KYKER

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Eva
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1893
8. AGE: Years: 51 | Months: | Days: | If less than one day: hr. min.
9. Birthplace: Washington Co. Tenn. (Town, county, and state)
10. Usual Occupation: Blacksmith
11. Industry or business:
FATHER 12. Name: Jessie Kyker
13. Birthplace: Tenn
MOTHER 14. Maiden Name: Whitmore
15. Birthplace: Tenn
16 (a) Informant: Dillon-Taylor Funeral Home
(b) Address: Jonesboro Tenn.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 1-26-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Victory
Location: Jonesboro, Tenn
18 (a) Funeral director: Wilson Keck Gee
(b) Address: 1219 N. Eutaw St.
JAN 26 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1944, at 6:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic alcoholism

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Williams M.D. and Medical Examiner.
Date signed 1-22-44

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20- L. H. Pierce 312 Med Arts Bldg Ma 7125

G 13366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G 13366 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 N. Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 N. Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sydney N. Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name ~~of husband or~~ wife Lucy Norris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14th 1858

8. AGE: Years	Months	Days	If less than one day
85	2	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Conductor
11. Industry or business B & O R. R.

FATHER
12. Name Isaiah Norris
13. Birthplace England

MOTHER
14. Maiden Name Sarah Ann (Un Known)
15. Birthplace Md.

16 (a) Informant Miss Eva Norris
(b) Address 314 N. Monroe St.

17 (a) Burial (b) Date thereof 1/27/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Date received JAN 26 1944 (b) Registrar Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25th 1944, at 5-16 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 1943 to Jan 24 1944, and that I last saw him alive on Jan 24 1944.

Immediate cause of death Carcinoma Scalp of head — Duration 3-4 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Harrell Pierce M.D.
Address 312 Medical Arts Bldg Baltimore, Md. Date signed 1/26/44

G 13367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13367 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Feb. 18, 1942
(e) Length of stay in Baltimore (yrs., mos., or days) Since Feb. 18, 1942

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 5315 Connecticut Avenue, N.W. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM EDWARD REYNOLDS (Admiral C.G. retired)

3 (b) If veteran, name war: Sp.Am. & World War #1
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Wid.
6 (b) Name of husband or wife: Nellie Bates
6 (c) If alive, give age: Dec. years
7. Birth date of deceased (mo., day, yr.): Jan. 11, 1860
8. AGE: Years 84 Months 0 Days 11 14 If less than one day: hr. min.
9. Birthplace: Montgomery County, Md. (Town, county, and state)
10. Usual Occupation: CG(ret) Admiral
11. Industry or business: --

FATHER
12. Name: Greenbury Reynolds
13. Birthplace: Montgomery County, Md.

MOTHER
14. Maiden Name: Naomi Fawcett
15. Birthplace: England

16 (a) Informant: Records, U.S.Marine Hospital
(b) Address: Baltimore, Md.

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof Jan 26. 1944 (month) (day) (year)
(c) Cemetery or crematory Location Washington D.C.

18 (a) Funeral director Robt. E. M. Walter & Co.
(b) Address Pratt & Stricker Sts

26 1944 (Date received by registrar) (b) Huntington Williams, Registrar

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MEDICAL CERTIFICATION P.

20. DATE OF DEATH January 25, 1944, at 3:06 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb.18, 1942 to Jan.25, 1944 and that I last saw him alive on Jan. 25, 1944.

Immediate cause of death: Bilateral bronchial pneumonia; & Coronary occlusion, old

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: As above

Interval between onset and death: approx. 2 weeks; Unk.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J.C.Archer M. D.
Address: Baltimore, Md. Date signed: 1/26/44

39248

will call Tom for G 13368 Lind

G 13368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1739 Patapsco Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1739 Patapsco Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Etta Eslein

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles Eslein

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1878

8. AGE: Years 65 | Months 5 | Days 10 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Henry Callender
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Dollie Phillips
15. Birthplace: Maryland

16 (a) Informant: Annie Hamilton
(b) Address: 3627 Lee Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-44 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Anne Arundel County, Md.

18 (a) Funeral director: Geo. P. Schwab
(b) Address: 2101 Frederick Ave.

19 (a) JAN 26 1944 (Registrar) (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 19 44, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1, 1943, to 1-25 1944, and that I last saw her alive on 1-24 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 mo.
Due to: Arteriosclerosis	2 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: A. Sellod
Address: 707 E. Fort Ave. Date signed: 1-25-44

G 13369

G 13369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Jefferson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucilla Carver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: b | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882 12/5

8. AGE: Years 61 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace St Marys Co Md (Town, county, and state)

10. Usual Occupation

11. Industry or business none

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Annie Bennett
15. Birthplace St Marys Co Md

16 (a) Informant Mrs Davis
(b) Address 1612 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 28 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Anne Arundel Co Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) (Date rec'd by registrar) (b) Lester Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1944 at 9 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1944 to Jan 27 1944 and that I last saw h[illegible] alive on Jan 1944

Immediate cause of death: Acute cardiac dilatation

Due to: Pulmonary tuberculosis

Due to: Cirrhosis

Other Conditions: Anemia

Cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas A. Dine M. D.

Address 118 Prospect Pl Date signed 1-26-44

2 YEAR

13370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122A

Registered No. G 13370

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 THICKET Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY Love Clarke
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower.
6 (b) Name of husband or wife FRANCES TAYLOR
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1874

8. AGE: Years 69 | Months 5 | Days 30 | If less than one day hr. min.

9. Birthplace MARYLAND. (Town, county, and state)
10. Usual Occupation LAWYER
11. Industry or business

FATHER 12. Name HENRY Clarke
13. Birthplace Virginia

MOTHER 14. Maiden Name Agnes YOST
15. Birthplace MARYLAND.

16 (a) Informant SELF.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Henry M. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 JAN 27 1944 (b) Huntington Williams, M.D. (Registrar)
(Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1944 at 10:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1944 to 11-26 1944.
and that I last saw h[illegible] alive on 11-25 1944.

	Duration
Immediate cause of death Cardio-respiratory failure	2 hrs.
Due to Bronchopneumonia	24 hrs.
Due to	
Other Conditions Coronary arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation 11-24-43
Major findings of operation: Strangulated inguinal hernia - Left
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hurl Bowers M.D.
Address Date signed 2nd 1944

G 13371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G 13371 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 N.Chester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 66 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 N.Chester Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME William E.Woods

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	215-03-3753

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jessie Woods
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-3-1877

8. AGE: Years	Months	Days	If less than one day
66	3	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clerk Cont.Can Co.
11. Industry or business

FATHER
12. Name William L.Woods
13. Birthplace Adams Co.Penna

MOTHER
14. Maiden Name Mary A Hellen
15. Birthplace Baltimore,Md,

16 (a) Informant Mrs. Jessie Woods
(b) Address 1818 N.Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem
Location Baltimore Md.

18 (a) Funeral director Albert L.Wilt Jr
(b) Address 1606 N.Chester Street

19 JAN 27 1944 (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1944, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1933, to Jan. 25, 1944, and that I last saw h~~e~~im alive on Jan 25, 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 2 weeks
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weiss, M.D. M. D.
Address 1927 E. North Ave. Date signed 1/26/44

13372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 E

G 13372 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 N.Washington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 N.Washington Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Thomas N.Bremont

3 (b) If veteran, name war	3 (c) Social Security Account No.
National Guard	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie Bremont
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1867

8. AGE: Years	Months	Days	If less than one day
76	7	26	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Sign Painter
11. Industry or business

FATHER
12. Name John Bremont
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Fadley
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Minnie Bremont
(b) Address 1315 N.Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-44 (month) (day) (year)
(c) Cemetery or crematory Balto Cemetery
Location North Ave & Rose St

18 (a) Funeral director Albert I Nitz Jr
(b) Address 1606 N. Chester Street

19 (c) JAN 27 1944 (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1944, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 28 1943 to January 25 1944 and that I last saw him alive on January 25 1944

Immediate cause of death	Duration
Sarcoma of Right Humerus	1 Year.
Due to Cachexia and Metastasis	1 Month.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg M. D.
Address 2025 E Monument Date signed 1/26/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G 13373

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air (If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. # 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ward
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Hugh J. Ward
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 18-1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	6	8		

9. Birthplace Md. Harford Co. Md. (Town, county and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER
12. Name Joseph McGuigan
13. Birthplace Harford Co. Md.
14. Maiden Name Anna Farrell
15. Birthplace Harford Co. Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29/44 (month) (day) (year)
(c) Cemetery or crematory St Ignatius
Location near Bel Air Md
18 (a) Funeral director Dean & Sons
(b) Address Bel Air Md

JAN 27 1944 (Date rec'd by registrar) (b) Hampton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1944 at 6.36 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1944 to 1-26 1944 and that I last saw h[illegible] alive on Jan. 26 1944

Immediate cause of death — Duration

Coronary Occlusion — Immed.
Due to Coronary Arteriosclerosis
Due to

Other Conditions Unexplained Hematuria
Secondary Anemia
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Roger B. Scott M. D.
Address Johns Hopkins Hosp. Date signed 1-26-44

correct age is especially important. Physician: please write the cause of death clearly and legibly.

VS 180

13374

447654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 13374
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 McCulloh
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-12

8. AGE: Years 31 | Months 6 | Days 7 | If less than one day: hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles E.F. Cohen
13. Birthplace Md

MOTHER
14. Maiden Name Aurelia K Page
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ✓ (Burial, cremation, or removal)
(b) Date thereof 1-29-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto, Md

18 (a) Funeral director Mrs George H Holland
(b) Address 1631 Edmondson Ave

19 JAN 27 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 25 1944 at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 13 1944 to JAN 25 1944 and that I last saw h.i M alive on JAN 25 1944

Immediate cause of death Lobar Pneumonia with septicemia due to pneumococcus type XVII — Duration: 2 days

Due to

Due to

Other Conditions Hodgkin's disease of lymphosarcoma — Duration: 10 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Dixon M. D.
Address Johns Hopkins Hospital Date signed

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ G 13375 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 E 20th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 E 20th St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Marie Elizabeth Bowman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Harvey J.
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23-1905

8. AGE: Years	Months	Days	If less than one day
38	1	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Rodney N. Thomas
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marie E Marsden
15. Birthplace Baltimore

16 (a) Informant Harvey J Thomas
(b) Address 410 E 20th St

17 (a) Burial, Cremation or Removal Bowman (b) Date thereof 1-29-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Leonard J Rusch
(b) Address 5305 Harford Road

19 JAN 27 1944 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1944 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1934 to Jan 1944 and that I last saw her alive on 1-25- 1944.

Immediate cause of death	Duration
(a) Chronic Myocarditis	3 Months
Due to Bronchial Asthma	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 1-26-44

VS 3

G 13376

BALTIMORE CITY HEALTH DEPARTMENT 94A ✓ G 13376

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 McCulloh Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM MASON

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife: Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace: S. Carolina (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mason
(b) Address: 1602 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-44 (month) (day) (year)
(c) Cemetery or crematory: Balto National
Location: Balto Md

18 (a) Funeral director: Mrs. Geo. A. Holland
(b) Address: 1631 Druid Hill Av

JAN 27 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25, 1944, at 8:10 A. M

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Asst Medical Examiner.
Date signed 1-25-44.

13377
YA-86120

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13377
Registered No. 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Mary Woodson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1898

8. AGE: Years	Months	Days	If less than one day
45	6	-	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Tom Bentley
13. Birthplace Va.

MOTHER
14. Maiden Name Emily Holman
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Jan. 27 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Rose M. Stallard
(b) Address 1631 Druid Hill Ave.

JAN 27 1944
(Date rec'd by registrar) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1944, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1944, to 1/24 1944, and that I last saw her alive on 1/24 1944

Immediate cause of death
Pneumonia
~~Due to~~ Pinkhosa of Lungs
& Syphilis

Duration
5 days
?

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mathews M. D.
Address B-P-H Date signed 1/24/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G 13378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 A

G 13378 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Vincent Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Vincent Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME George Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	A. A.	married

6 (b) Name of husband or wife Clara Harrison

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1878 ?

8. AGE: Years	Months	Days	If less than one day
65 66			hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant James Harrison
(b) Address 905 Whitecast Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Geo. G. Nelson
(b) Address 1303 Pennsylvania Ave. Huntington Williamsport, Md.

19 (a) JAN 27 1944 (Received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1944. at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1944. to 1/24 1944. and that I last saw h[illegible] alive on 1/24 1944.

Immediate cause of death Pneumonia

Due to

Due to La Grippe

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carson C. Johnson M.D.
Address 802 Penna Ave Date signed 1/26/44

VB 280

G 13379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13379 Registered No. 83 A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1359 n. Gilmore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1359 n. Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Washington Ball

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	married

6 (b) Name of husband or wife David Ball
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57 5 6			hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name George Ophier
13. Birthplace md

MOTHER
14. Maiden Name
15. Birthplace —

16 (a) Informant David Ball
(b) Address 1359 n. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pleasant St

19 (c) JAN 27 1944 (Registered by Registrar) (b) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1944, at 4 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1944 to Jan 27 1944 and that I last saw h[illegible] alive on Jan 27 1944.

Immediate cause of death Cerebral hemorrhage — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 715 Gorsuch Date Jan 27 44

13380

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 13380
Registered No.

CERTIFICATE OF DEATH 92A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4005 Belvieu Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 73/1/13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Belvieu Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----

3 (a) FULL NAME Edward Joseph Reilly, Sr.

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name ####### wife Agnes F. Kelly
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) 12/13/1870

8. AGE: Years	Months	Days	If less than one day
73	1	13	---- hr. ---- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Leather & Shoe Finding
11. Industry or business business

FATHER
12. Name Edward Reilly
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret King
15. Birthplace Ireland

16 (a) Informant Edward Joseph Reilly, Jr.
(b) Address 610 Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meurs & Son
(b) Address 805 N. Calvert St.

JAN 27 1944 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1944 at 6 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1941 to Jan 26 1944 and that I last saw him alive on Jan 23 1944.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Generalized Arterio-sclerosis & Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L Kurt Levy Dr. Kurt Levy M. D.
Address 2301 Garrison Blvd. Date signed 1/27/44

3381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13381
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 E. 30th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emilie D. Koenig

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced** Widow

6 (b) Name of husband or wife Oscar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11-1868

8. AGE: Years 75 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name Charles F. Klepper
13. Birthplace Germany

MOTHER
14. Maiden Name Virginia Lange
15. Birthplace Germany

16 (a) Informant Osca. C. Koenig
(b) Address 2006 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Jan. 28-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. York. Ave

18 (a) Funeral director John. G. Hodgson
(b) Address 3000 E. Balto. St

JAN 27 1944

(c) Received by Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1944 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1941 to 1/25 1944 and that I last saw her alive on 1/25 1944

Immediate cause of death Hypertensive Cardio Vascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Cole Toller M. D.
Address 5703 Harford Rd Date signed 1/26/44

3382

447984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13382

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Hempel Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Maria Scruggs
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-20-7105

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3-(2)-07
8. AGE: Years 36 | Months 10 | Days 23 | If less than one day hr. min.
9. Birthplace VA (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Allison Scruggs
13. Birthplace VA

MOTHER
14. Maiden Name Elizabeth
15. Birthplace VA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan. 28-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert E. Miller
(b) Address 1515 McElderry St

19. JAN 27 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN 25 1944, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 19 1944, to JAN 25 1944, and that I last saw h & R alive on JAN 25 1944

Immediate cause of death: Coronary occlusion?
Due to
Due to
Other Conditions: Acute dilatation — post operatured (Include pregnancy within 3 months of death)

Duration

Date of operation 1-19-44
Major findings of operation: Acute cholecystectomy.
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Saunders M.D.
Address Johns Hopkins Date signed 1/26/44

G 13383 ✓ G 13383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 36yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert A. Gooding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ~~Caroline Keating~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr-16-1864

8. AGE: Years 79 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Connecticut (Town, county, and state)

10. Usual Occupation Pensioned Post Office Clerk

11. Industry or business Post Office Clerk

FATHER
12. Name William Gooding
13. Birthplace South Carolina

MOTHER
14. Maiden Name Emeline Keating
15. Birthplace Connecticut

16 (a) Informant Herbert A Gooding
(b) Address 628 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director Wendell E Humphreys
(b) Address 1501 N. Broadway.

JAN 27 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1944 at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1944 to Jan 25 1944 and that I last saw h[illegible] alive on 1/25 1944

Immediate cause of death Cardio-Respiratory Failure — Duration 4 hrs.

Due to Intestinal Obstruction — 33 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/18/44

Major findings of operation: Tumor of Colon

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. D. McCracken M. D.

Address Date signed

VS 180

3384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered Number C 13384

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 S Sharp Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city limits write RURAL and give town)
(d) Street No. 830 S. Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1890

8. AGE: Years 50 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel J Fisby
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Martha Fisby
15. Birthplace Baltimore Md

16 (a) Informant Clifford Jones
(b) Address 830 S Sharp Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Isaiah L Brandon
(b) Address 1058 W Montgomery St

19 JAN 27 1944 (b) Huntington Williams M.D.
(Registered by number)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1944 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1944 to 1/24 1944, and that I last saw her alive on 11/24/44 19

Immediate cause of death Duration

Kyphoba

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Valeria M. D.

Address 1131 Hanover St Date signed 1/27/44

G 13385

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G 13385
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Carolineand Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5938 Kavon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie L. Barnes (Elsie L. Barnes)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William J. Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 11, 1878

8. AGE: Years	Months	Days	If less than one day
65	4	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nimrod C. Hart
13. Birthplace Unknown

MOTHER
14. Maiden Name Catherine Pedrick
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Eleanor Barnes
(b) Address 5209 Eugene Ave.

17 (a) Burial (b) Date thereof Jan. 28, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Ammerman
(b) Address 4510 Liberty Heights Ave.

JAN 27 1944
(Date filed by Registrar)
Huntington Williams, M.D.
Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25, 1944 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19, 1944 to Jan. 25, 1944, and that I last saw her alive on Jan. 25, 1944.

Immediate cause of death Acute Cardiac Failure

Due to Arteriosclerotic Cardiovascular Disease

Due to Arteriosclerotic Cardiovascular Disease

Other Conditions Hemiplegia (Right Side) Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Hyatt M. D.
Address 4 Joseph Hosp. Date signed 1/26/44

Notice: Age is especially important. Physicians please write the cause of death clearly and legibly.

G 13386

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83A

G 13386 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 St. John's Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Harwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Hall Claytor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1861

8. AGE: Years	Months	Days	If less than one day
82	10	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William C. Claytor
13. Birthplace Anne Arundel County, Md.

MOTHER
14. Maiden Name Gertrude Pindell
15. Birthplace Anne Arundel County, Md.

16 (a) Informant Mr. John Claytor
(b) Address 625 St. Johns Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Christ Church Yard
Location Owensville, Md.

18 (a) Funeral director Miller & Amos
(b) Address 1003 N. Eutaw St.

19 (a) JAN 27 1944 (b) [illegible] Registrar
(Date received by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1944, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944 to Jan 26 1944, and that I last saw her alive on Jan 25 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days
Due to: Arteriosclerosis - Hypertension — Gradual
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature W. H. Moody M. D.
Address 1403 Park Ave. Date signed 1/27/44

13387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13387

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0 N/A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5920 Smith ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Edward Philip Eder

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary M. P. Eder

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July - 1878

8. AGE: Years	Months	Days	If less than one day
65	06	—	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business A & P Tea Co

FATHER
12. Name Ed A Eder
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. M. Eder
(b) Address 5920 Smith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Govs Md

18 (a) Funeral director J. J. Foley & Sons
(b) Address 128 W Eight St

19 JAN 27 1944 Huntington Williams N.Y.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25- 1944, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 1-26-44

VS 151

13388 J.O. #85965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16 1a

✓ G 13388 Registered No.

Correct age if especially important — PLEASE: print. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs. 44 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs. 44 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Elliott St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Van Atta, Baby Girl (Delores)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 13, 1944

8. AGE: Years	Months	Days	If less than one day
			2 hr. 44 min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ronald Van Atta
13. Birthplace Pa.

MOTHER
14. Maiden Name Delores Zeller
15. Birthplace Md.

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof Jan 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Balto City Hosp. Location 4940 Eastern Avenue

18 (a) Funeral director Balto. City Hosp.
(b) Address 4940 Eastern Avenue

JAN 27 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1944, at 8:50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1944 to 1-13 1944 and that I last saw h. alive on 1-13 1944.

Immediate cause of death: Congential Atelecasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Crawford M.D.
Address Balto. City Hosp. Date signed 1-31-44 M. D.

VS 150

13389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13389 Registered No.

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 MILLBROOK ROAD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Born?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 Mill Brook Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGIANNA B. KEYES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: Geo H Keyes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 19, 1874

8. AGE: Years: 69 | Months: 01 | Days: 7 | If less than one day: hr. min.

9. Birthplace PHILADELPHIA, PA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name unknown

13. Birthplace "

14. Maiden Name ALCORN

15. Birthplace unknown

16 (a) Informant NORMAN CHASE KEYES
(b) Address 105 MILLBROOK ROAD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 44 (month) (day) (year)

(c) Cemetery or crematory Green Mount
Location Baltimore, Md

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address McCulloh Orchard & Eutaw Sts

JAN 27 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1944 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 23 1944, to Jan 26 1944 and that I last saw her alive on Jan 26 1944

Immediate cause of death: Cerebral Vascular accident — Duration: 4 hrs

Due to

Due to

Other Conditions: Influenza — 4 days

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

Signature Francis W Kluck M. D.

Address 715 Park Ave Date signed 1/27/44

Correct age in especially important cases; physicians please write the causes of death clearly and legibly.

13390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G 13390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood.
(c) Hospital or institution: Unversity Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Hamilton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Robert Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1872

8. AGE: Years	Months	Days	If less than one day
71	9	18	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Tailor - The Hub Co.

11. Industry or business

FATHER
12. Name -- Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Miller
(b) Address 4307 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 27 1944 (Date received by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1944, at 3 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1944 to 1/26 1944 and that I last saw him alive on 1/26 1944

Immediate cause of death Metastatic Carcinoma — Duration

Due to Carcinoma of pylorus and of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/19/44

Major findings of operation: Carcinoma of Stomach & multiple liver metastases

Date of autopsy? & Biopsy? Metastases to liver and mediastinum

PHYSICIAN

Underline the cause to which deaths are charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William B. Hagan, M.D.
Address Univ. Hosp. Date signed 1/26/44

13391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓ G 13391

Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland
(a) Street address 2908 Violet Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Kennedy Ave. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ? years

3 (a) FULL NAME Gertrude Gruber

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Nathan Gruber
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
58				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Aron Garfield
13. Birthplace Russia

MOTHER
14. Maiden Name Lillian ?
15. Birthplace Russia

16 (a) Informant Nathan Gruber
(b) Address 1900 Kennedy Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-28-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Leyne Inc
(b) Address 6 E. Baltimore St.

19 (a) JAN 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1944, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943, to Jan. 27 1944, and that I last saw her alive on Jan. 26 1944.

Immediate cause of death Coronary Thrombosis — Duration 3 hrs.

Due to Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton S. Sacker, M.D.
Address University Hospital Date signed 1/27/44

VS 2

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 13392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2904 Orleans St.
(c) Hospital or institution:

6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Johnson

3 (b) If veteran, name war -----

3 (c) Social Security Account No. 215-03-1586

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barbara Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1887

8. AGE: Years 56 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Coffee Analyst

11. Industry or business H. M. Wagner & Co.

FATHER
12. Name John T. Johnson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna O. Marfield
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Barbara Johnson
(b) Address 2904 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28/44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Maurer & Sons
(b) Address 2024 Orleans St.

JAN 27 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1944, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1943 to Jan 24 1944.
and that I last saw h alive on January 24 1944.

Immediate cause of death: Congestive Heart Failure — Duration: 3 mos.

Due to: Coronary Thrombosis — 3 mos.

Due to:

Other Conditions: Associated Nephritis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Ogle, M. D.
Address 2005 E. Monument St
Date signed 1/26/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 E.Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 E.Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Dashner Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
---	---	Male	White	Widow	Elizabeth Dashner	years

7. Birth date of deceased (mo., day, yr.) July 17, 1863

8. AGE: Years	Months	Days	If less than one day
80	6	7	hr. min.

9. Birthplace Balto.Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Herman Dashner
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Emma Needer
(b) Address ~~2330~~ 2430 E.Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto.Md.

18 (a) Funeral director Philip Newing Sons
(b) Address 2024 Orleans St.

19 JAN 27 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24/44 19 , at 4.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943, to Jan 24 1944, and that I last saw him alive on Jan 22 1944.

Immediate cause of death Myocarditis — Duration 7

Due to General debility arteriosclerosis — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Klemm M.D.
Address 2023 E. Monument St. Date signed 1/24/44

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G 13394 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Arlington Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Yvonne M. Merrick

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	-

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17 1941

8. AGE: Years	Months	Days	If less than one day
2	3	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER 12. Name Alonzo Merrick
13. Birthplace Wilmington N. C.

MOTHER 14. Maiden Name Evelyn L. Norris
15. Birthplace Baltimore Maryland

16 (a) Informant Evelyn L. Merrick
(b) Address 220 N. Amity Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie L. Williams
(b) Address 722 N. Schroeder St.

JAN 27 1944 (Date rec'd by registrar) (b) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1944, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation.

Due to House fire.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-24-44 at 9:45 A.M. M.
(b) Where did injury occur? 206 N. Arlington Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury House was afire.

23. Signature Henry L. Wollenweber, M.D. M.D.
Medical Examiner.
Date signed 1-25-44 per. Robert Lee Gratton M.D.

VS 151

13395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 13395
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 W. Fayette st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 W. Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Patterson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Jane Patterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1844

8. AGE: Years 60 | Months — | Days — | If less than one day: hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mary Frazier
(b) Address 518 S. Mulberry st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29-44 (month, day) (year)
(c) Cemetery or crematory Woodlawn Mem.
Location

18 (a) Funeral director Miss Katie R. Williams
(b) Address 3229 W. Lombard St.

JAN 27 1944 Katie R. Williams M.P.
(Date received by Registrar) (Signature of Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 10, M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1943 to Jan 26 1944, and that I last saw him alive on Jan 16 1944

Immediate cause of death Cardiac Degeneration
Due to Myocarditis
Due to Hypostatic Pneumonia
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Strauss M. D.
Address 1111 Lee Date signed 1/26/44

Approved: Robert Lee Graham M.D. Jan 27 1944

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

13396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C 13396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 8A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 231 E. Heath St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Eva Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1896

8. AGE: Years	Months	Days	If less than one day
47	6	3	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Balto Transit Co.

FATHER
12. Name August Martin
13. Birthplace Balto.

MOTHER
14. Maiden Name Katherine Kern
15. Birthplace Germany

16 (a) Informant Mrs Dolores B. Price
(b) Address 1602 Patapsco Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md

18 (a) Funeral director G. Howard Evans
(b) Address 1400 E. Hanley

19 (a) JAN 27 1944 (Registered Number) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1944, at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed Jan 25, 1944

VS 181

G 13397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13397 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Melvin Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Barnes

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-20-43

8. AGE: Years	Months	Days	If less than one day
	11	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Earl Barnes
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Barnes
15. Birthplace Md.

16 (a) Informant Catherine Barnes
(b) Address 1420 Melvin Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna, Ave

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

JAN 27 1944

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25-1944 at 6:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular pneumonia

Due to

Other Conditions Congenital nonluetic syphilis Cont.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malecio M.D. Medical Examiner.
Date signed 1-26-44

IO #80923 (1)

13398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 13398 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos. 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Port St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Valentine Blotkamp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1858

8. AGE: Years	Months	Days	If less than one day
85	8	5	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name William Blotkamp
13. Birthplace Holland

MOTHER
14. Maiden Name Elizabeth Sedbrock
15. Birthplace Holland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Lexington & Arch Sts.

JAN 27 1944 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1944, at 2:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 1/26 1944 and that I last saw him alive on 1/26 1944.

Immediate cause of death: Bronchopneumonia; cardiac failure
Due to A.S.C.V.D.
Due to
Other Conditions Gen. arterio-sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post

Duration: 33d.

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sargmon M. D.
Address BCH Date signed 1/26

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G 13399 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Light St.
(c) Hospital or institution South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 dy
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 S Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Mae Young

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-7850

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Edward J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/9/1895

8. AGE: Years	Months	Days	If less than one day
48	1	16	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER
12. Name James F. Price
13. Birthplace Md.

MOTHER
14. Maiden Name Mary K. Nash
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1318 Hilton

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director Jas. L. McCully
(b) Address 130 E. Fort Ave

19 (a) JAN 27 1944 (Date received by Local Registrar) (b) Huntington, Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25 1944 at 4 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1944 to 1-25 1944, and that I last saw her alive on 1-25 1944

Immediate cause of death Cerebral Hemorrhage — Duration 1 dy

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. J. MacDonald M.D.
Address 1213 Light Date signed 1-25-44

VS 8

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 13400 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 E. Overland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 544 Main St. Elkridge Md.
(If rural give location)
(e) If foreign born, how long in U. S. A.) years

3 (a) FULL NAME Mary A. Soper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife late Wm. H. Soper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1866

8. AGE: Years 77 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Elkridge Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

MOTHER / FATHER

12. Name John O'Malley

13. Birthplace Ireland.

14. Maiden Name Bridget

15. Birthplace Ireland

16 (a) Informant Mrs Mary A. Bond

(b) Address 544 Main St Elkridge, Md.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 1/29/44 (month) (day) (year)

(c) Cemetery or crematory St Augustines Cem.

Location Elkridge Md.

18 (a) Funeral director John F. Conway & Son

(b) Address 901 Hollins St.

19 (a) JAN 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1944. at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1944. to Jan 26 1944. and that I last saw her alive on Jan 25 1944.

Immediate cause of death Chronic myocarditis — Duration 6 years

Due to

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury none

23. Signature L. L. Conley M. D.

Address 5106 Harford Road Date signed 1-26-44

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

Registered No. C 13401

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 S. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 132 S. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife late John Boone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19th 1876.

8. AGE: Years 67. | Months 7 | Days 6. | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER 12. Name John Callahan

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary McHale

15. Birthplace Ireland

16 (a) Informant Mrs. Sadie Smith

(b) Address 132 S. Carey St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location 4300 Old Frederick Rd

18 (a) Funeral director John Cowan & Son

(b) Address 900 N Fulton Ave

19 JAN 27 1944 (Date received by local registrar) (b) Huntington Wilson, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1944 at 12 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1943 to Jan 24 1944, and that I last saw h[er] alive on Jan 24 1944.

Immediate cause of death Cardiac Failure — Duration 2 hrs.

Due to Myocarditis — Duration 6 wks.

Due to

Other Conditions Influenza

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Coral Gordon M. D.
Address 2201 W Northern Date signed 1-25-44

Please write clearly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

VS 180

G 13402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13402 Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. b
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 422 N. Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lonnie Johnson

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex Male | **5. Color or race** Colored | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife Mary Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 35 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace S. C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace S.C

MOTHER
14. Maiden Name Ida Martin
15. Birthplace S C

16 (a) Informant Mary Johnson wife
(b) Address S.C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-44 (month) (day) (year)
(c) Cemetery or crematory Shipped
Location Black Stock S.C

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 JAN 27 1944 (Date received by Registrar) (b) Huntington Williamsburg, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1944, at 9:20 P. M.

21. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural and subarachnoid hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 22, 1944 9:00 P. M.
(b) Where did injury occur? Broadway Market
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Struck by cars

23. Signature Robert Lee Slaton M.D. Medical Examiner.
Date signed January 24, 1944

VS 151

G 13403

VO #75[illegible] 13403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 5 mos 15 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anna Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Brooks Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1919

8. AGE: Years	Months	Days	If less than one day
24	11	13	hr. min.

9. Birthplace Alabama. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Ernest Hamilton
13. Birthplace ?

MOTHER
14. Maiden Name Mattie Mayfield
15. Birthplace Ala.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 28 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayzer Sanders
(b) Address 1412 E. Preston St

19 (a) (Date received by registrar) (b) Registrar
JAN 27 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1944, at 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1943, to 1/25 1944, and that I last saw her alive on 1/25 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Mattone M. D.
Address B. C. H. Date signed 1/25/44

G 13404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13404 Registered No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 E Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Meadows
3 (b) If veteran, name war
3 (c) Social Security Account No. 233-36-0520

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1927

8. AGE: Years 16 | Months 17 | Days 4 | If less than one day hr. A min.

9. Birthplace Logan, West Virginia (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan (month) 30 (day) /44 (year)
(c) Cemetery or crematory Logan
Location West Virginia

18 (a) Funeral director Foley & Mitchell Bros
(b) Address 700 Cutaway place Baltimore

19 (a) (Date received by registrar) (b) Registrar

JAN 27 1944

VS 180

Huntington, Williams, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1944 at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1944 to Jan 26 1944 and that I last saw him alive on Jan 26 1944

Immediate cause of death: Meningococcemia — Duration

Due to Waterhouse-Friderichsen

Due to syndrome

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Bennington M. D.

Address J H H Date signed 1-27

13405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 13405

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1114 E. Prata St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert Dunday

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name

13. Birthplace

MOTHER — 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL JAN 27 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 27 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

9656

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1944 at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Yeater M.D. Medical Examiner.

Date signed January 3, 1944

VS 161

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Register No. G 13406

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
D.A. Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 270 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Richard Clark

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
57			..... hr. ..... min.

9. Birthplace .....
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) ..... **(b) Date thereof**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JAN 27 1944

18 (a) Funeral director Commissioner of Health
(b) .....

19 (a) JAN 27 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1943 3d A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury .....

23. Signature Hugh B. McHale M.D.
Medical Examiner.

Date signed 12/27/43

0685

VS 151

13407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1144

G 13407
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Southern Ave, Emp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Richard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1	1		hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JAN 27 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 27 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

0684

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1944, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Interstitial Pneumonia.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fraton M.D.
Medical Examiner.
Date signed Jan. 7, 1943.

13408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

G 13408

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Usual address 824 E. Baltimore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	2		hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JAN 27 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 27 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1944, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Nutritional Diarrhoea

Due to Prematurity.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 1/17/44

0683

VS 181

G 13409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 13409 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Fayette Street
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County * *
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 John Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country *

3 (a) FULL NAME Wm. K. Landrigan

3 (b) If veteran, name war No

3 (c) Social Security Account No 216-12-6018

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife * *

6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) Feb 2 - 1870

8. AGE: Years 73 Months 11 Days 24 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired-Bookkeeper

11. Industry or business

FATHER 12. Name Patrick Landrigan

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Kellum

15. Birthplace Ireland

16 (a) Informant Susan A. Tierney

(b) Address 1104 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-29-44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location 414 Frederick Road

18 (a) Funeral director Chas. F. Eugene's Son

(b) Address 118 W. Mt. Hunterton Ave Hunterton Publications, Md.

(c) (b)

JAN 27 1944 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH [redacted] 1-26 1944, at 7.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1943, to 1-26 1944, and that I last saw h[redacted] alive on 1-26 1944.

Immediate cause of death Hypostatic Pneumonia

Due to Arteriosclerotic Heart disease

Due to

Other Conditions Fractured neck left Femur.
(Include pregnancy within 3 months of death)

Date of operation 1-10-44

Major findings of operation: Fractured neck - left Femur.

of autopsy: Hypostatic Pneumonia

Duration 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-27-43 at about 2 P.M.
(c) Where did injury occur? Balto, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? *
(e) Means of injury Fracture of neck Fell on floor left Femur

23. Signature Louis Vogel Jr. M. D.

Address Bon Secours Hosp Date signed 1-26-44

VS 3

Approved: Robert Lee Preston M.D. Jan. 27 1944

G 13410

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13410 Registered No. 100 R

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith
(c) Hospital or institution: 26 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Foster Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. M. Clarona Habicht

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) M 25 1899

8. AGE: Years	Months	Days	If less than one day
44	2	1	hr. min.

9. Birthplace New York City N. Y. (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business Religious

FATHER
12. Name Thomas Habicht
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Slomik
15. Birthplace Poland

16 (a) Informant Sr. M. Stan. Rostka
(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Fayette Ave

18 (a) Funeral director Geo. M. Enid & Son
(b) Address 861 N. Wolfe St

19 (a) [illegible] (b) Huntington Williams Mgr.

JAN 27 1944

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1944 at 7.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1944 to Jan. 26 1944 and that I last saw h[illegible] alive on Jan. 26 1944.

Immediate cause of death Chronic ulcer leg varicose veins.
Due to Infected phlebitis
Due to Pulmonary Embolus

Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. J. Kirby M. D.
Address 1108 North Ave Date signed Jan 27-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13411

BALTIMORE CITY HEALTH DEPARTMENT X 159

CERTIFICATE OF DEATH

G 13411
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner and Dukeland Aves
(c) Hospital or institution: West Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No 67 Severnby Court Apt G
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Stansbury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1944

8. AGE: Years	Months	Days	If less than one day
			hr. 20 min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Duray Stansbury
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Janet Mary Heyser
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Wm. Stansbury
(b) Address 67 Severnby Court, Apt G

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JAN 2 1944
18 (a) Funeral director Commissioner of Health
(b) Address

JAN 2 1944 (b) Huntington Williams M.D.
(Date filed by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944, to Jan. 21 1944, and that I last saw him alive on Jan. 21 1944.

Immediate cause of death Respiratory failure

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
8

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Gottman M. D.
Address 901 Fenelon Ave Date signed 1/24/44

0687 Middle River, Md.

447083
G 13412

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13412
Registered No. 478

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Garrett
(c) City or town Ketzmillers
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie McCrobie

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Gertie McCrobie
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Dec 17 1889

8. AGE: Years	Months	Days	If less than one day
54	3	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Retired Coal Miner

FATHER
12. Name Joseph McCrobie
13. Birthplace Md.

MOTHER
14. Maiden Name Stella McCrobie
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, removal) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Swanton Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St
(c) Date rec'd by registrar JAN 27 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 19 44 at 2:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1944, to Jan. 26 1944 and that I last saw him alive on Jan. 26 1944

Immediate cause of death: Respiratory failure — Duration

Due to Carcinoma of lung

Due to

Other Conditions advanced pulmonary tbc
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R Birmingham M.D.
Address J H H Date signed 1-27

CORRECT AGE is especially important — If unknown, please write the cause of death clearly and legibly.

JO #75803 G 13413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 13413 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 9 mos. 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Schmidt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1900

8. AGE: Years	Months	Days	If less than one day
43	2	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Ford Balto. Filling Station

FATHER
12. Name Henry Schmidt (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Florance Schultz (d)
15. Birthplace Maryland

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Trinity
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Paul St

19 (a) JAN 27 1944 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1944, at 3:55 ~~P~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1944 to 1-26 1944 and that I last saw h[illegible] alive on 1-26 1944.

Immediate cause of death: Pulmonary TBC — Duration: 7
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Matt M. D.
Address B. C. H. Date signed 1/25/44

Correct age is especially important. Please write the cause of death clearly and legibly.

G 13414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G 13414 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Russell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward M. Beasley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Ada Beasley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st 1902

8. AGE: Years	Months	Days	If less than one day
41	7	24	hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)
10. Usual Occupation Leader
11. Industry or business Bethlehem Ship Yards

FATHER
12. Name Unknown Beasley
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Eva Pearl Beasley
(b) Address 1014 Russell St

17 (a) Burial (b) Date thereof 1/26/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

JAN 27 1944
(Date rec'd by registrar)
19 (a) (b) Huntington Williams M.D.
Registrar

VE 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1944, at 10:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1943, to Jan 25 1944, and that I last saw him alive on Jan 25 1944.

Immediate cause of death	Duration
Chronic myocarditis with hypertensive cardio-vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul A. Lukato M. D.
Address 213 Light St. Date signed Jan. 26 1944

G 13415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G 13415 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 N. Port St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola M. Riley (Riley)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married, widowed, or~~ divorced: Divorced

6 (b) Name of husband: William Riley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12* 1903

8. AGE: Years: 40 | Months: 11 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Joshua Robinson
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Margaretta Schmidt
15. Birthplace: Balto Md.

16 (a) Informant: Mrs Mary E. De Moss
(b) Address: 708 E. 41st St

17 (a) Balto (Burial, ~~cremation, or removal~~) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location " Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 (a) (b) Registrar

JAN 31 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1944, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia with pleurisy

Due to

Other Conditions Fatty degeneration of liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Trotter M.D. Medical Examiner
Date signed Jan 27 1944

G 13416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/92D

G 13416 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 Fonthill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) 29 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Fonthill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Ann Sutherland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ William Sutherland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9th 1870

8. AGE: Years	Months	Days	If less than one day
73	7	17	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name John Milne
13. Birthplace Scotland

MOTHER
14. Maiden Name Unknown Rennie
15. Birthplace "

16 (a) Informant Mary Sutherland
(b) Address 335 Fonthill Ave

17 (a) Burial (Burial, cremation, or removal?) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JAN 27 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26th 1944, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to Jan 26 1944, and that I last saw her alive on Jan 25 1944

Immediate cause of death: Cerebral Thrombosis

Duration
14 yr.

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. McCallum M. D.
Address 332 Frederick Ave Date signed 1-26-44

G 13417

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13417 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 E. Preston St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME George Meffett Smith.

3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-01-5422

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Minnie Estelle Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19 1868

8. AGE: Years	Months	Days	If less than one day
75	4	7	hr. min.

9. Birthplace Eastern Shore Md (Town, county, and state)
10. Usual Occupation Retired Foreman
11. Industry or business Atlantic Waste Paper Corp

FATHER
12. Name Geo. Washington Smith
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Harrison Carey
15. Birthplace Eastern Shore Md

16 (a) Informant Clarence H. Smith (Son)
(b) Address 2850 Wood Broad Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Baltimore Md.

18 (a) Funeral director Williams Colt Inc
(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

JAN 27 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1944, at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1943, to June 26 1944, and that I last saw h[illegible] alive on June 25 1944.

Immediate cause of death	Duration
Bronco Pneumonia	2 d.
Due to Mitral Regurgitation Decompensated	2 mo
Due to Chronic Parenchymatous Nephritis	7 mo
Other Conditions Hypertension	2 mo
Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J F A Stevens M. D.
Address 2878 Harford Rd Date signed 1/26/44

G 13418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G 13418 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 Millington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Millington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Micheal.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Female	white	widow.

6 (b) Name of husband or wife Charles Micheal.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1881

8. AGE: Years	Months	Days	If less than one day
62	7	4	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Flora B. Mullen
(b) Address 422 Millington Ave.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Jan 28/44 (month) (day) (year)
(c) Cemetery or crematory Elkton
Location Virginia

18 (a) Funeral director Edmonds & Sonman
(b) Address 3615-17 Edmondson Ave

19 (a) Filed Jan 27 1944 (by registrar) Thorrington Williams M.D. Registrar
(b) Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Jan 27 1944, and that I last saw her alive on Jan. 26 1944

Immediate cause of death: Cerebral Haemorrhage — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmonds & Sonman M.D.
Address 4037 Falls Rd. Date signed 1/27/44

VS 150

13419
To #66100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48A

G 13419
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Orleans St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Lutz

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-9723

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Chas. H. Lutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1897

8. AGE: Years	Months	Days	If less than one day
46	2	30	29 hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Charwoman
11. Industry or business New Amsterdam Ins. Co.

FATHER
12. Name Clement Henkel
13. Birthplace Delaware

MOTHER
14. Maiden Name Katherine Linderman
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 29 44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Herring Lowe
(b) Address 2024 Orleans St

JAN 28 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1944, at 7:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21-44 to 1-26 1944 and that I last saw h[e] alive on 1-26 1944.

Immediate cause of death: Carcinoma Cervix
Due to C metastases

Duration
2

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Type of place)
(e) Means of injury

23. Signature Donald Hebb M. D.
Address Balt. City Hosp. Date signed 1-28-44

correct if it is [illegible]

120
447391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

561

G 13420
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Salvador, S. A.

3 (a) FULL NAME Jose Urbina

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/13/37

8. AGE: Years 6 | Months 6 | Days 14 | If less than one day: hr. min.

9. Birthplace S. A. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jose M. Urbina
13. Birthplace S. A.

MOTHER
14. Maiden Name Beatriz Paz.
15. Birthplace S. A.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Jan 28/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3804 Frederick ave
18 (a) Funeral director John Whitelegg & Sons
(b) Address 1900 Eastern Place, Huntington Williams, Mgr

19 JAN 28 1944 (Date rec'd by registrar)

Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-27 1944, at 1 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-8 1944, to Jan-27 1944, and that I last saw him alive on Jan-27 1944.

Immediate cause of death MENINGITIS — STAPH. AURENS
Due to POST-OPERATIVE INFECTION
Due to
Other Conditions CEREBELLAR TUMOR REMOVED (Include pregnancy within 3 months of death)
Date of operation January 10, 1944
Major findings of operation: CEREBELLAR TUMOR
of autopsy: —

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm W. Chambers M. D.
Address Johns Hopkins Hosp. Date signed 1/27/44

correct age if anything is wrong

13421 447565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5/B

Registered No. G 13421

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Landsdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 - 4th ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME (William G. Weber) WILLIAM GEORGE WEBER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Christiana Julia Siehler

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 10-4-63

8. AGE: Years 80 | Months 3 | Days 22 | If less than one day: hr. ____ min. ____

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Weber
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Young
15. Birthplace Md

16 (a) Informant Mrs. John Struss
(b) Address 4th Ave., Lansdowne, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 (a) JAN 28 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 26 1944 at 4:29 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 11 1944 to JAN 26 1944, and that I last saw HIM alive on JAN 26 1944.

Immediate cause of death: pulmonary edema — Duration: 1 Dy

Due to: Cardiac failure — arteriosclerotic heart disease

Due to:

Other Conditions: Carcinoma of prostate — ?
(Include pregnancy within 3 months of death)

Date of operation 11/24/43 Carcinoma

Major findings of operation: prostate

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Russell B. Wilds M.D.
Address Johns Hopkins Hosp. Date signed 1/28/44

Correct ages are especially important. Physicians: please write the causes of death clearly and legibly.

3422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ G 13422

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2811 Echodale Ave.

(c) Hospital or institution:

2-7-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2811 Echodale Ave. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH MICHEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John Henry Michel

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) February 11, 1876

8. AGE: Years	Months	Days	If less than one day
67	11	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Louis Huether

13. Birthplace Fulda Germany

MOTHER

14. Maiden Name Christina Loechel

15. Birthplace Germany

16 (a) Informant John Henry Michel

(b) Address 2811 Echodale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cemetery

Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address North Ave. & Broadway

19 (a) JAN 28 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 250

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH January 25 1944 at 3.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 19 44 to Jan 25 19 44 and that I last saw her alive on Jan 25 19 44.

Immediate cause of death Coronary Heart Disease

Chronic Myocarditis

Duration

Due to

Due to

Other Conditions Chronic Colitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature George A. Lefler M. D.

Address 432 S. Patterson Pk. Date signed 1/27/44

13423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 13423
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Lawnwood Ave.
(c) Hospital or institution:
Church Home and Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 East North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VESTA MARY HALL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1882

8. AGE: Years	Months	Days	If less than one day
61 yrs.	8	20	20 hr. 45 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Secretarial
11. Industry or business

FATHER
12. Name Cary Dorsey Hall, Sr.
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Elizabeth Stansbury Gill
15. Birthplace Baltimore, Md.

16 (a) Informant Dr. Elmer Gill Hall
(b) Address 1311 E. North Ave.

17 (a) Burial (b) Date thereof 1/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

JAN 28 1944 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1944 at 2:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1944 to 1/26 1944, and that I last saw h[illegible] alive on 1/25 1944.

Immediate cause of death	Duration
Cardiac & Respiratory Failure	
Due to Bilateral pleural effusions	
Due to Carcinoma of breast c advanced metastases.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Carcinoma of Breast.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Steven Halsey, M. D.
Address Church Home Hospital Date signed 1/26/44

G 13424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a ✓

G 13424 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 S Conkling St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 - 8

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 S. Conkling
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary P. Schlueter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Henry H Schlueter
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug 17. 1884

8. AGE: Years	Months	Days	If less than one day
59	5	9	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Simon Wolf
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Babcock
15. Birthplace Germany

16 (a) Informant Henry H Schlueter
(b) Address 228 S Conkling St

17 (a) Burial (b) Date thereof 1-29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md

18 (a) Funeral director Ulysses Funeral Home
(b) Address 2946 Orleans St.

19 JAN 28 1944 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1944. 8 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-1939 to 1-26-1944 and that I last saw her alive on 1-26-1944

Immediate cause of death Carcinoma of cervix — Duration 2 mos

Due to

Due to

Other Conditions Arteriosclerosis Cardiovascular Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Constantine M.D.
Address 234 S Conkling St Date signed 1-29-44

Correct age is especially important. Physicians: please write the cause of death clearly and legibly

13425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 830 G 13425 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 W. Pratt St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 W. Pratt St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME J. Henry Graeser

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Married

6 (b) Name of husband or wife Martha J. Graeser
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) February 6-1872

8. AGE: Years	Months	Days	If less than one day
71	11	21	hr. min.

9. Birthplace Baltimore, Md (City, county, and state)
10. Usual Occupation (Retired)
11. Industry or business —

FATHER 12. Name August Graeser
13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Raab
15. Birthplace Md

16 (a) Informant Martha J. Graeser
(b) Address 1731 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director W. P. Shepard Son
(b) Address 65 W. Fayette St

19 (a) JAN 28 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27th 1944, at 6 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14-1944 to 1-27 1944, and that I last saw h[im] alive on 1-27 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 2 weeks
Due to Generalized Arteriosclerosis
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —
23. Signature Morris B. Schreiber
Address 514 S. Fulton Ave Date signed 1-28-44 M. D.

VS 150

426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G 13426

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Aves
(c) Hospital or institution:
St. Agnes 29-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (~~Yrs.~~, mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (29)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Eagle St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3. (a) FULL NAME Lewis Gericke ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12/2/43 1 months

8. AGE: Years	Months	Days	If less than one day
—	1	24	— hr. — min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Alexander Gericke
13. Birthplace Maryland

MOTHER
14. Maiden Name Estella Walsh
15. Birthplace Maryland

16 (a) Informant Alexander Gericke
(b) Address 2022 Eagle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Irvington - Frederick Rd.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

JAN 28 1944 Huntington Williams M.D.
(Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1944, at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw her alive on 1/27 19 44.

Immediate cause of death Pulmonary thrombosis

Due to Aspiration pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryson M. D.
Address St Agnes Hosp Date signed 1/27/44

correct age is especially important. Physicians: please write the name of cause clearly and legibly.

13427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 97

G 13427

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Raspeburg (If outside city or town limits, write RURAL and give town)
(d) Street No. Trump Mill Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. William Breyer

3 (b) If veteran, name war no

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ruth E. Breyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1878

8. AGE: Years 65 | Months 4 | Days 03 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name Gottlieb Breyer
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Wm. Breyer
(b) Address Raspeburg 6 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 31 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Leasman Funeral Home
(b) Address 7401 Belair Rd.

JAN 28 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1944, at 12 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 19 44, to Jan 27 1944, and that I last saw him alive on Jan 27 1944.

Immediate cause of death Congestive heart failure c pulmonary edema

Due to Hypertensive arteriosclerotic

Due to

Other Conditions Arteriosclerotic gangrene lower legs (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St. Joseph's Hosp. Date signed 1-29-44

VS 150

13428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 13428
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Catonsville
(c) Hospital or institution: St. Agnes Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (23)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa W. Smuck

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wm. E. Smuck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1869

8. AGE: Years 74 | Months 7 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland-Havre de Grace
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Taylor Lyon (Decd)
13. Birthplace Maryland, Cecil Co.

MOTHER
14. Maiden Name Maria L. Pennington
15. Birthplace Maryland

16 (a) Informant Mr. Wm. E. Smuck
(b) Address 1828 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1944, at 1:55a M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw her alive on 1/27 1944.

Immediate cause of death Cardiac failure — Duration

Due to Myocardial degeneration

Due to

Other Conditions Pulmonary

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony J. Bryan M. D.
Address St. Agnes Hospital Date signed 1/27

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 13429 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balt. General Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Light St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Campion H. Pomeroy

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 218-07-0900

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Bessie Pomeroy
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1889

8. AGE: Years	Months	Days	If less than one day
55	0	21	____ hr. ____ min.

9. Birthplace St. Mary's Co., Md. (Town, county, and state)
10. Usual Occupation Ship Fitter
11. Industry or business Bethlehem Shipbuilding Co.

FATHER
12. Name Mr. Charles H. Pomeroy
13. Birthplace Va.

MOTHER
14. Maiden Name Ruth Clements
15. Birthplace Md.

16 (a) Informant Mr. Cecil A. Pomeroy
(b) Address 1224 N. Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1944 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1944 to 1-27 1944, and that I last saw him alive on 1-27 1944.

Immediate cause of death: cerebral hemorrhage — Duration: ____

Due to: hypertensive Cardio vasc. disease — Duration: ____

Due to: ____ — Duration: ____

Other Conditions: ____ — Duration: ____

(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Charles H. Mitchell M.D.
Address 1213 Light St. Date signed 1-27-44

13430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 13430

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Lyndon
(c) Hospital or institution: Md Gen Hosp 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Delaware Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME Katie Eberle (Kate Eberle)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George Eberle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1872

8. AGE: Years 71 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Lamp

11. Industry or business

FATHER
12. Name William Hartlaub
13. Birthplace Md.

MOTHER
14. Maiden Name Bernetta Fuhrig
15. Birthplace Md

16 (a) Informant Mr. George Eberle
(b) Address 4703 Delaware Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) 2/2/1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1944 to Jan 27 1944, and that I last saw h[illegible] alive on Jan 26 1944.

Immediate cause of death: Pneumonia (post operative)
Duration: 2 days

Due to

Due to

Other Conditions Diabetes & Rt. Mid. thigh amputation
(Include pregnancy within 3 months of death)

Major findings:
Of operations Right mid-thigh amputation.
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Q. Mitchell M. D.
Address Md. Gen Hosp Date signed 2-2-1944

VS 1

13431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

G 13431
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2010 Sulgrave Ave.
(c) Hospital or institution:

27-15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 Sulgrave Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ALEXANDER SCOTT WORKMAN

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 174-01-3541

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife: Opal M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1883

8. AGE: Years	Months	Days	If less than one day
60	--	29	hr. min.

9. Birthplace Wagee, Ohio (Town, county, and state)
10. Usual Occupation Sales Manager
11. Industry or business Frick Co.

FATHER
12. Name Samuel P. Workman
13. Birthplace Ohio

MOTHER
14. Maiden Name Katherine Scott
15. Birthplace Iowa

16 (a) Informant Mrs. Opal M. Workman
(b) Address 2010 Sulgrave Ave. 9

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Balto., Md.
(b) Huntington Williams, M.D.

JAN 28 1944
(Date rec'd by registrar)
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1944, at 7.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944 to Jan 27 1944, and that I last saw him alive on Jan 27 1944

Immediate cause of death	Duration
Angina Pectoris	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugo D. Bubert M. D.
Address 913 East Hoffman St Date signed Jan 27/44

Cause, age is especially important. Physicians: please write the causes of death clearly and legibly.

13432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

C 13432
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. Carey St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Gross

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Rosie Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1874

8. AGE: Years	Months	Days	If less than one day
69	10	11	hr. min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Gross
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Md

16 (a) Informant Rosie Gross
(b) Address 222 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30-44 (Month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Wm Kato R. Gilliams
(b) Address 522 N. Schroeder St.

19 JAN 28 1944 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1944, at 3 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11- 1944 to 1-26 1944 and that I last saw h alive on 1/25/1944.

Immediate cause of death Hypertensive Cardio-Vascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Wilson M. D.
Address 1514 Division St. Date signed 1/28/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2153 86165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G 13433
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Madison Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-07-4092

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1903

8. AGE: Years 40 | Months 10 | Days 25 | If less than one day: hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Railroad Trackman

11. Industry or business B. & O. Railroad

FATHER
12. Name Lewis Smith
13. Birthplace North Carolina

MOTHER
14. Maiden Name Georgia ?
15. Birthplace Alabama

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Miss Katie R. Williams
(b) Address 922 N. Johnson St.
JAN 28 1944 (Date received by registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1944, at 3:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 19 44, to 1-27 1944, and that I last saw h[illegible] alive on 1-27 1944.

Immediate cause of death
Cardiac failure
Due to Hypertension & arteriosclerotic disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1 mo
1 year

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Pam[illegible] Nathan M. D.
Address B. C. H. Date signed 1-27

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13434
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1650 N. Bentelou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE FRIEDMAN (Betsy)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business -

FATHER
12. Name Russia
13. Birthplace -

MOTHER
14. Maiden Name Russia
15. Birthplace

16 (a) Informant Mrs. Friedman (Son)
(b) Address 1650 N. Bentelou St

17 (a) Burial (b) Date thereof 1-28-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Kurah
Location Harford Avenue

18 (a) Funeral director Isaac Levin Inc
(b) Address 1439 E. Balto St

19 (a) JAN 28 1944 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1944 at 4:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1944 to 1-28 1944, and that I last saw her alive on 1-27 1944.

Immediate cause of death Uremia

Due to Chronic glomerulonephritis

Due to

Other Conditions Diabetes
Hypertension no known cause
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving S Arnick M. D.

Address Sinai Hosp. Date signed 1-28-44

13435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13435
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2412 Puget St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Puget St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Nicholas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Evelyn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-1911

8. AGE: Years	Months	Days	If less than one day
32	11	12	hr. min.

9. Birthplace Balto Md (town, county and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name John W. Nicholas
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Marjorie Johnson
15. Birthplace Balto Md

16 (a) Informant Evelyn Nicholas
(b) Address 2412 Puget St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto Md

18 (a) Funeral director Wm. Geo. H. Stellard
(b) Address 1601 Druid Hill Ave

19 (a) (b) Huntington Williams, M.D.

JAN 28 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1944 at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24-44 1944 to Jan 26 1944.
and that I last saw h alive on Jan 26 1944.

Immediate cause of death Lobar pneumonia

Duration 3 days

Due to Toxic condition of kidneys

Duration 2 years

Due to

Other Conditions Was in Sanatorium 2 times
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams
Address 2708 Hollins Ferry Rd Date signed 1/27/44 M.D.

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

13436
447720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V
569

G 13436
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State VA (b) County
(c) City or town CAMBRIA
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Champ Lester
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: MARIE
6 (c) If alive, give age 37 years
7. Birth date of deceased (mo., day, yr.) 4-14-00
8. AGE: Years 43 | Months 9 | Days 14 | If less than one day: hr. min.
9. Birthplace W. VA (Town, county, and state)
10. Usual Occupation FARMING
11. Industry or business

FATHER
12. Name GORDON Lester
13. Birthplace VA

MOTHER
14. Maiden Name MARY C GRAY
15. Birthplace VA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery or crematory
Location Christiansburg, Va

18 (a) Funeral director Mrs. J. Fitzgerald Sons
(b) Address Baltimore, Md.

19 JAN 28 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN - 28 1944 at 4:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 14 1944 to JAN 28 1944 and that I last saw him alive on JAN 28 1944.

Immediate cause of death: Brain Tumor — Duration: 2 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-15-44

Major findings of operation: Brain Tumor

of autopsy:

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugo V. Rigby M. D.
Address Johns Hopkins Hosp. Date signed 1-28-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

13437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G 13437

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 Jackson St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Jackson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bonnie G. Hunt

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife –

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 2/23/1931

8. AGE: Years 12 | Months 11 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace St. Dennis, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name John F. Hunt
13. Birthplace Holland, N.J.

MOTHER
14. Maiden Name Lillian Harnsburger
15. Birthplace Port Republic, Va.

16 (a) Informant John and Lillian Hunt (F&M)
(b) Address 1712 Jackson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie, Md

18 (a) Funeral director William M. Mareck
(b) Address 715 Light St.

19 JAN 28 1944 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24th 19 44, at 6.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1943 to 1-24, 1944, and that I last saw h er alive on 1-24 1944.

Immediate cause of death: Acute Leukemia (myeloid)

Duration: 5 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Folland M. D.
Address 707 E. Fortune. Date signed 1-25-44

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13438 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3709 S. 6th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 S. 6th (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William C Meyers Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Widowed

6 (b) Name of husband or wife Cissie D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18 1878

8. AGE: Years	Months	Days	If less than one day
65	5	8	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Machanist

11. Industry or business Koppers Co

FATHER 12. Name John F. P. Meyers

13. Birthplace Md

MOTHER 14. Maiden Name Louisa Doenges

15. Birthplace Md

16 (a) Informant Wm C Meyers Jr

(b) Address Cockeysville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location 2930 Frederick Ave

18 (a) Funeral director William M Marecks

(b) Address 715 E. 42 St

19 JAN 28 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1944, at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 19 44 to Jan 26 19 44, and that I last saw h[illegible] alive on Jan 26 19 44.

Immediate cause of death coronary occlusion — Duration

Due to hypertension & cardio vascular dis — Duration

Due to 0 — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip W Kuster M.D.

Address 302 Patapsco Av Date signed 1/27/44

VS 250

G 13439 — BALTIMORE CITY HEALTH DEPARTMENT — G 13439

CERTIFICATE OF DEATH

107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2536 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Conway

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 88 | Months | Days | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Stepton Nelmms
13. Birthplace Va

MOTHER 14. Maiden Name unobtainable
15. Birthplace

16 (a) Informant Gertrude White
(b) Address 2536 Druid Hill Ave

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)

(c) Cemetery or crematory Lancaster Co Va
Location Va

18 (a) Funeral director Wm. H. Nelson
(b) Address 1103 Pleasant St
(Date rec'd by registrar) JAN 28 1944 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1944 at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1944 to 1/24 1944.
and that I last saw her alive on 1/24 1944

Immediate cause of death Broncho Pneumonia — Duration

Due to — 4 D

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. J. Hasselwander M. D.
Address 1705 Pa Ave Date signed 1/27/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

M. D. B. 1208-a

G 13440 ✓ G 13440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 50

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 N. Gilmor St., Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Viola Tongue

(a) Residence: No. 1339 N. Gilmor St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Isaac Tongue

6. DATE OF BIRTH (month, day, year) 190?

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Private family

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md

FATHER

13. NAME Charles Croston

14. BIRTHPLACE (city or town) (State or country) Baltimore, Md

MOTHER

15. MAIDEN NAME Lottie Allsup

16. BIRTHPLACE (city or town) (State or country) Baltimore, Md

17. INFORMANT Inez Lackey
(Address) 1339 N. Gilmor St Same

18. BURIAL, CREMATION, OR REMOVAL
Place Burial Arcadia Date 1/29/44 19...

19. UNDERTAKER Geo. W. Kelson
(Address) 303 Preston St

20. Filed JAN 29 1944, Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) January 26, 1944

22. I HEREBY CERTIFY, That I attended deceased from Dec. 15 1942 to Jan. 26 1944

I last saw her alive on Jan. 25. 1944. Death is said to have occurred on the date stated above, at 6 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinomatosis	1 yr.
Other contributory causes of importance:	
Cancer of Breast	

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Wm Ronald Bando M. D.

(Address) 2445 Druid Hill Ave

13441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

116

Registered No. G 13441

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll Co.
(c) City or town Westminister (If outside city or town limits, write RURAL and give town)
(d) Street No. 196 E. Green St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Clough

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irvin H. Clough

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 1-18-03

8. AGE: Years 40 | Months 0 | Days 9. | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Samuel Adeline

13. Birthplace Va.

14. Maiden Name Carrie Tippett

15. Birthplace Va.

16 (a) Informant Friends

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery Co. Inc. Baltimore, Md.

18 (a) Funeral director J. Francis Reese

(b) Address Westminster, Md.

19 (a) [illegible] Registrar Huntington Williams, M.D.

JAN 28 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1944 at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1943 to Jan 27 1944 and that I last saw her alive on Jan 27 1944.

Immediate cause of death ? Massive Collapse of Lungs or Pulmonary Embolism.

Due to Rupture of Oesophagus with Lung Abcess

Due to

Other Conditions Gastrostomy + Thoracotomy with Abcess drainage

(Include pregnancy within 3 months of death)

Date of operation 1-4-44

Major findings of operation: Abcess of Right Lung.

of autopsy Atelectasis RLL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George Bunch M.D.

Address Johns Hopkins Hosp. Date signed 1-28-44

G 13442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

✓ G 13442 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 Frederick Ave.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Healey.

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife John Patrick Healey
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Unknown 1866

8. AGE: Years	Months	Days	If less than one day hr.	min.
77				

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation house work -
11. Industry or business at home

FATHER
12. Name John Heavenig
13. Birthplace Ireland.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Ireland

16 (a) Informant Mrs Francis P. Healey
(b) Address 234 N Chapel Lane

17 (a) burial (b) Date thereof 1/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral.
Location 4300 Old Frederick Road

18 (a) Funeral director John J Cowan Son
(b) Address 901-03 Baltimore Street

19 (a) 1944 (b) ...
(Date received by registrar) Registrar
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26, 1944 at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1943 to Jan. 26 1944.
and that I last saw DR alive on Jan. 25 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 1 day

Due to Hypertension

Due to Nephritis

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J Cowan
Address 2 W Read St Date signed 1/28/44 M.D.

JAN 28 1944

Please type or print plainly. Physicians: please write the cause of death clearly and legibly. Space 22 is especially important.

G 13443

G 13443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 W. Camden Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy Stembaugh

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Chester Co. Pa. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Lewi Stembaugh
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Calvin Hebber
(b) Address Womelsdorf, Pa.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Jan. 31 1944 (month) (day) (year)
(c) Cemetery or crematory Trinity Union Cem. - Rehrersburg - Pa.
Location

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1600 N. North avenue

19 (a) (Date received by Local Registrar) (b) Registrar

JAN 28 1944 Thurlow Williams M.D. for B.H.L. Wollenweber, by Howard J. Kneller, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1944, at 10:55 P. M.

21. I certify that I took charge of the remains described above, held an enquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage
Arteriosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry L. Wollenweber, M.D. Medical Examiner.
Date signed 1-28-44.

G 13444

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13 | a

G 13444
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Kingsway Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 N Rosedale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva L. Fahey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thos E Fahey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1874

8. AGE: Years 69 | Months 07 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation ~~Waitress~~

11. Industry or business Undertaker

FATHER
12. Name Louis F Barranger
13. Birthplace Baltimore

MOTHER
14. Maiden Name Helena Yokel
15. Birthplace Baltimore

16 (a) Informant Mr. M E Fahey
(b) Address 1827 N Rosedale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey Sons
(b) Address 1827 N Rosedale

JAN 28 1944
(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-1944 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24-1943 to 1-26-1944 and that I last saw h alive on 1-25-1944.

Immediate cause of death Apoplexy — Duration 1-22-44

Due to Arteriosclerosis cardio-renal disease — Duration 1 year

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. B. Lybert M. D.
Address 2402 Harford Rd Date signed 1-28-44

VS 3

G 13445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G 13445
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Cathedral Street
(c) Hospital or institution:
Severn Apartments (HOME)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Cathedral St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NO

3 (a) FULL NAME
JOHNETTA NEWELL BARTHELOW RAYNER

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife HARRY S. RAYNER
6 (c) If alive, give age XXX years

7. Birth date of deceased (mo., day, yr.) June 30, 1859

8. AGE: Years 84 | Months 6 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore - Maryland
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER
12. Name Lycurgus Barthelow
13. Birthplace Philadelphia, Penna.

MOTHER
14. Maiden Name Avis Denning
15. Birthplace Maryland

16 (a) Informant Mrs. H. W. Classen (Daughter)
(b) Address Tuscany Apartments - City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1944 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address (WFWooden-Suc.) 108 W. North Ave.

19 (a) (Date received by registrar) JAN 28 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1940 to Jan 27 1944, and that I last saw her alive on Jan 26 1944.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerosis

Due to Hypertension

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Finch M.D.
Address Medical Arts Bldg. Date signed 1/28/44

G 13446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13446 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Calverton Road
(c) Hospital or institution:
Convent of Good Shepherd
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Calverton Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Magdalen of St. Domitilla (Alberta Carter)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 22-1907

8. AGE: Years	Months	Days	If less than one day
37	—	5	hr. min.

9. Birthplace St. Mary's Co., Southern Md. (Town, county, and state)
10. Usual Occupation Sewing
11. Industry or business

FATHER
12. Name Patrick Ferdinand Carter
13. Birthplace St. Mary's Co., Southern Md,

MOTHER
14. Maiden Name Mary Carter
15. Birthplace St. Mary's Co., Southern Md.

16 (a) Informant Sr. Mary of St. John Eudes
(b) Address 301 Calverton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29-1944 (month) (day) (year)
(c) Cemetery or crematory St. Peter's Cemetery
Location Baltimore Md

18 (a) Funeral director Geo. L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

JAN 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Jan 26 1944 and that I last saw her alive on Jan 27 1944.

Immediate cause of death (Enter only one cause per line for (a), (b), and (c).)
(a) Pneumonia
(b) Heart failure
(c)

Duration
(a) 7 days
(b)
(c)

Due to
Due to
Other Conditions Pulmonary tuberculosis
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations: —
of autopsy: —

10 days
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Ewin M. D.
Address 518 Medical Arts Bldg. 1/28/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13447 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1171 Cleveland St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1171 Cleveland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Robert Catterton

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Hattie M. Catterton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1881

8. AGE: Years 62 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Self

FATHER
12. Name James B. Catterton
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Catterton
15. Birthplace Md.

16 (a) Informant Alvin F. Catterton
(b) Address 4011 Elderon Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) Huntington Williams, M.D. (Person acting as registrar) Registrar

JAN 29 1944

MEDICAL CERTIFICATION 7.05

20. DATE OF DEATH Jan. 26, 1944 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1944 to 1-26 1944 and that I last saw h[illegible] alive on 1/26 1944

Immediate cause of death: Acute Cardiac Failure — Duration 1 da
Due to: Acute Myocarditis, Bilateral Pulmonary Infarcation
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Joseph P. Lankasty, M.D.
Address 629 W. Lexington St. Date signed 1/27/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13448

Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Pittsburgh Penn. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5704 Hampton St. (If rural give location)
(e) Citizen of foreign country? ~~Yes~~ No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Helena Gibney

3 (b) If veteran, name war W.
3 (c) Social Security Account No. None

4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Christopher A. Gibney
6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) August 30 1878

8. AGE: Years 65? Months 4 Days 28 If less than one day ..... hr. ..... min.

9. Birthplace Pittsburgh (Town, county, and state)
10. Usual Occupation H W
11. Industry or business

FATHER
12. Name Daniel Haberty
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Hugerty
15. Birthplace Ireland

16 (a) Informant Son / Capt Regt Gibney
(b) Address Ft Geo Meade Md

17 (a) Burial (b) Date thereof 1/28/44
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Calvary
Location Pittsburgh Pa

18 (a) Funeral director Thilhorn & Son
(b) Address 1219 St Paul St

19 (a) Date received by registrar Huntington Williamsport Md
JAN 28 1944
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1944, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 24 1944, to Jan. 28 1944, and that I last saw her alive on January 28 1944.

Immediate cause of death Respiratory Failure — Duration

Due to Cerebral Hemmorrhage

Due to Hypertensive Cardio Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howland Edward Day M. D.
Address Womens Hospital Date signed Jan 27 1944

G 13449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G 13449 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7301 Bayfront Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roberta May Brownsberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

(b) Name of husband or wife Harold

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) About 1898

8. AGE: Years About 45 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Fayette City Penna. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John W. Perrie

13. Birthplace Penna

MOTHER 14. Maiden Name Minnie Martin

15. Birthplace Penna

16 (a) Informant Husband

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-44 (month) (day) (year)

(c) Cemetery or crematory Location Fayette City Pa

18 (a) Funeral director Wendell E. Humphreys

(b) Address 1501 N. Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1944 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1944 to Jan. 28 1944, and that I last saw her alive on Jan. 28 1944.

Immediate cause of death Congestive Heart failure — Duration

Due to

Due to

Other Conditions Carcinoma of cervix Obesity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Christian J. Richter M. D.

Address St. Joseph's Hosp. Date signed 1/28/44

G 13450 — BALTIMORE CITY HEALTH DEPARTMENT — G 13450 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Green Spring Manor Apts. Park Heights & Slade Aves.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Ab't 25 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Green Spring Manor Apts. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME: BERNARD A. HELLER.

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Florence S. Heller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1874.

8. AGE: Years 69 Months 4 Days 14 If less than one day hr. min.

9. Birthplace Charlottesville, Va. (Town, county, and state)
10. Usual Occupation Manufacturer of
11. Industry or business Drugs. (Leewy Drug Co.)

FATHER
12. Name Bernard A. Heller.
13. Birthplace Vienna.

MOTHER
14. Maiden Name Fannie Letterman.
15. Birthplace Charlottesville, Va.

16 (a) Informant Mr. L. Samler.
(b) Address Green Spring Manor Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ 30/44. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Sinai Sorrow Assn.
(b) Address 1902 Eutaw Place.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27th. 1944 at 1.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1936 to Jan 27 1944 and that I last saw h[illegible] alive on Jan 26 1944.

Immediate cause of death: Myocardial Insufficiency — Duration: 1 wk.
Due to: Hypertension — 8 yrs.
Due to: Arteriosclerosis — 10 yrs.
Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations No
Of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph N. Kerby M. D.
Address 11 E. Chase St. Date signed 1/27/44

Va 5 Huntington Hospital, Md.

G 13451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G 13451

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4322 Woodlea Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4322 Woodlea Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH LILLIAN TURNER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	female	white	widow

6 (b) Name of husband or wife Francis King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1883

8. AGE: Years	Months	Days	If less than one day
60	7	22	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Gilman Country School

FATHER
12. Name Francis Philip Marsden
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annie Rogers
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Alvin Strobel
(b) Address 4322 Woodlea Ave.

17 (a) Burial (b) Date thereof 1/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 29 1944 (c) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1944 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1944 to 1/26 1944
and that I last saw her alive on 1/26 1944

Immediate cause of death Uremic Convulsions — Duration 1 Day

Due to Carcinoma of Uterus and Bladder. — Duration about 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Amalia E Link
Address 241 E. Lake Ave Date signed 1/27/44 M. D.

18452 Incomplete! Cemetery?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G 13452
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4219 Springwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4219 Springwood Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL E. WAGNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1872

8. AGE: Years	Months	Days	If less than one day
71	3	23	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Balto. Stock Exchange

FATHER
12. Name John Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Timmons
15. Birthplace Germany

16 (a) Informant Mrs. Mary E. Wagner
(b) Address 4219 Springwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1944 at 8 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1938 to 1-27 1944 and that I last saw h/m alive on 1-27 1944

Immediate cause of death: Cerebral Arteriosclerosis (Encephalomalacia) — Duration: 6 YRS +

Due to

Due to

Other Conditions: Carcinoma of Stomach — 6 Mos (?)
Arterial Hypertension — 6 YRS +
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Kracke M.D.
Address 6304 Belair Rd. Date signed 1/27/44 M. D.

correct age if especially important. If stillborn, give weight. If unknown, write "unknown." Cause of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

13453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109

G 13453 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home & Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Weaver (Alice R. Weaver)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife James E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-4-64

8. AGE: Years	Months	Days	If less than one day
80	0	23	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Occupant of old ladies' home
11. Industry or business

FATHER
12. Name Thomas N. Harbaugh
13. Birthplace Balto.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Jas. Rennous Weaver
(b) Address 3617 Crossland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 29 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 19 44 at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 19 44 to 1-27 19 44, and that I last saw h[illegible] alive on 1-27 19 44.

Immediate cause of death Pneumonia — Duration 7 days

Due to

Due to

Other Conditions senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Steven Haldt M. D.
Address CAH Date signed 1/27/44

correct age is especially important. Regulations require that one cause of death shall be given.

G 13454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 13454 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
55 54			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name Lewis Rodgers

13. Birthplace Va

MOTHER 14. Maiden Name Susie

15. Birthplace Va

16 (a) Informant Mollie Burr

(b) Address 708 North Gilmor Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29 1944 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn

Location Baltimore City

18 (a) Funeral director Leonard A Hagan

(b) Address 661 Baltimore St

19 (a) JAN 29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-1944 at 12 55 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Cervical Vertebra

Due to

Other Conditions Subdural Hemorrhage. Carcinoma of Uterus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:

(a) Date of injury 1-11-44 at 12 A M.

(b) Where did injury occur? 226 N. Carey St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Fell down main steps.

23. Signature Howard J Thomas M.D.
Medical Examiner.

Date signed 1-23-44

G 13455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13455

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 S. Hanover St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 S. Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME James E. Hicks Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1943

8. AGE: Years	Months	Days	If less than one day
	10	13	4 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Hicks
13. Birthplace Richmond, Va

MOTHER 14. Maiden Name Elouise Walker
15. Birthplace Rock Hill, S. C.

16 (a) Informant James Hicks
(b) Address 622 S. Hanover St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 30 44 (month) (day) (year)

(c) Cemetery or crematory
Location Rock Hill, S. C.

18 (a) Funeral director James A Hayes
(b) Address 142 Wolfe St
Huntington Williams Mort

19 (c) [illegible] Registrar

JAN 29 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 28 1944 at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1944 to Jan 28 1944 and that I last saw him alive on Jan 27 1944.

Immediate cause of death Acute Bronchitis

Due to Whooping Cough

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Trawick M. D.

Address 1 W Lee Date signed 1/28/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

JD 486074

13456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13456
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 West Biddle St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Joshua Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1902

8. AGE: Years 42 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual Occupation: Unemployed

11. Industry or business

FATHER
12. Name: Henry (d)
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Records, Balto. City Hospitals
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director: Adolphus Halstead
(b) Address: 918 Druid Hill Ave.

JAN 29 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24, 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1944, to 1-24 1944, and that I last saw h[illegible] alive on 1-24 1944.

Immediate cause of death: Uremia — Duration: 5 days

Due to: Nephritis chronic with hypertension — Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Paul Mattina M. D.
Address: B. C. H. Date signed 1/25/44

correct age is especially important. Physicians: please write in ink and in full. Do not use abbreviations or figures.

VS 180

13457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 13457

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Sarah Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Barnes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 10 1943

8. AGE: Years	Months	Days	If less than one day
	5	16	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Walbert L. Barnes.
13. Birthplace NC

MOTHER
14. Maiden Name Elizabeth Sompson
15. Birthplace NC

16 (a) Informant Elizabeth Barnes
(b) Address 1023 Sarah St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Hall
(b) Address 1568 Druid Hill Ave.

JAN 27 1944

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1944, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchial Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Feeter M.D.
Medical Examiner.
Date signed January 27, 1944

VS 151

KABRAUN

G 13458

13458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 S. Monastery Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 S. Monastery (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Kapraun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced widower

6 (b) Name of husband or wife Rose Seifert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 - 1860

8. AGE: Years 83 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Conrad Kapraun
13. Birthplace ?

MOTHER
14. Maiden Name Christian Mellis
15. Birthplace ?

16 (a) Informant Helen Kapraun
(b) Address 218 So. Monastery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5303 Harford Road

19 (a) JAN 29 1944 (Date rec'd by registrar) at Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1944 to Jan 25 1944 and that I last saw him alive on Jan 25 19 44.

Immediate cause of death Myocardial failure
Pulmonary congestion

Due to Myocarditis

Due to Old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas S. Baum M. D.
Address Med Arts Bldg Date signed 1-27-44

PLEASE WRITE CLEARLY. Physicians: please write the cause of death clearly and legibly. Be sure that the correct age is especially important.

13459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 13459 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 E. North Avenue
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 E. North Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Fenner

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George F. Fenner

6 (c) If alive, give age – – years

7. Birth date of deceased (mo., day, yr.) Dec. 1st, 1869

8. AGE: Years 74 | Months 1 | Days 27 | If less than one day ##### min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name (Unknown) Brooks

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Elizabeth Crawford

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Isabelle Mueller (Da...

(b) Address 604 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1944 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 JAN 29 1944 Received by Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1944 to Jan 28 1944 and that I last saw her alive on Jan 13 1944

Immediate cause of death
Due to Carcinoma of the breast

Due to

Other Conditions Enteral Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno. H. Pearce M. D.

Address 2105 Eutaw Date signed Jan 29/44

I certify that to the best of my knowledge and belief the above statements are true, complete and correct. Age is especially important. Physicians: please write plainly.

3460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13460

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Driveway and 31st St.,
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo12da
(e) Length of stay in Baltimore (yrs., mos., or days) 1mo12da

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Cecil
(c) City or town Port Deposit
(If outside city or town limits, write RURAL and give town)
(d) Street No. ---------
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MYRTLE O. ARMSTRONG

3 (b) If veteran, name war ----

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ------

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/22/90

8. AGE: Years 53 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Port Deposit, Maryland
(Town, county, and state)

10. Usual Occupation Stenographer--US PHS,

11. Industry or business Supply Depot, Perry Point, Md.

FATHER
12. Name David Armstrong,
13. Birthplace Port Deposit, Md.

MOTHER
14. Maiden Name Clara ~~Lenn~~ Lamm
15. Birthplace Port Deposit, Md.

16 (a) Informant Records-US Marine Hospital,
(b) Address Baltimore, Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1944 (month) (day) (year)

(c) Cemetery or crematory West Nottingham
Location Colora, Cecil Co Md

18 (a) Funeral director Chas. Patterson & Son
(b) Address Perryville, Md.

JAN 29 1944
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1944 at 6:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17, 1943, to Jan. 29, 1944, and that I last saw him alive on Jan. 29, 1944.

Immediate cause of death: Carcinoma of the left breast with multiple metastasis ~~xxxxxxx~~ involving the liver, kidneys, and peritoneum. — Duration: 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H C Quinn, M.D.
Address US Marine Hospital, Baltimore, Md. Date signed 1/29/44

Please correct age in especially important. Payments, please write

13461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1206

G 13461 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Grundy Ste
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S. Grundy Ste (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis A. Kirsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-8-1911

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Crown Cork & Seal Co

FATHER
12. Name Louis F. Kirsch
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary A. Arnold
15. Birthplace Balto. Co. Md.

16 (a) Informant Parents
(b) Address 600 S. Grundy Ste.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-31-44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location O'Donnell St & Ed.

18 (a) Funeral director John E. Connelly
(b) Address 418 Eastern Ave

19 (a) Date received (Registrar) Harrington Williams, M.D. Registrar

JAN 29 1944
VS 155

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27-44 19 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23-43 19 to 1-27-44 19, and that I last saw him alive on 1-24-44 19.

Immediate cause of death
Chronic Lymphatic Anemia
Due to Intestinal Colitis
Due to
Other Conditions Ulcerative Colitis

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Costantino, M.D.
Address 3 W. Lombard St. Date signed 1-28-44

13462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 13462
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave.
(c) Hospital or institution St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S. Mt Olivet Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Isakalos (Isakalop)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 13 | Months | Days | If less than one day hr. min.

9. Birthplace Vandergrift, Penna (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Nick Isakalos
13. Birthplace Greece

MOTHER
14. Maiden Name Jane Markotsos
15. Birthplace Greece

16 (a) Informant Father
(b) Address 10 S. Mt Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md.

18 (a) Funeral director Francis Reed
(b) Address West Minster, Md

19 JAN 29 1944 (Date rec'd by registrar) (b) Signature of Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1944, at 88 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1944 to 1/27 1944 and that I last saw him alive on 1/27/44 19

Immediate cause of death Extensive Metastases to Lungs

Due to Osteogenic Sarcoma Left Leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D. M. D.
Address St. Agnes Hosp Date signed 1/27/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 13463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46a

C 13463 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun + Fayette Sts
(c) Hospital or institution: Franklin Sq. Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 Hanover St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Thomas Johnson

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Marcia Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-11-1877

8. AGE: Years	Months	Days	If less than one day
66	4	16	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business

MOTHER / FATHER
12. Name Thomas
13. Birthplace Baltimore, Md
14. Maiden Name Tyson
15. Birthplace Baltimore Md

16 (a) Informant Thomas M. Johnson Jr
(b) Address 3811 Hanover St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md
18 (a) Funeral director Leonard D. Covington
(b) Address 21 W. 25th St
19 (a) JAN 29 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1944, at 2-20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1944 to 1/27 1944, and that I last saw him alive on 1/27 1944.

Immediate cause of death Carc. of Esophagus — **Duration**

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Lucas M.D.
Address Grad. Sq. Hosp. Date signed 1/29/44

VS 8

G 13464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G 13464 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1901 Eutaw Place
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 Eutaw Place (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lena E. Culverhouse

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John H. Culverhouse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1867

8. AGE: Years	Months	Days	If less than one day
74	7	19	hr. min.

9. Birthplace Massachusetts (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Joseph Culverhouse
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Houston
15. Birthplace Mass.

16 (a) Informant Dr. J. B. Culverhouse
(b) Address 1901 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

JAN 29 1944 (Date received by Registrar)

(b) Huntington for Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1944, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1944 to 1-27 1944 and that I last saw her alive on 1-27 1944

Immediate cause of death: Apoplexy — Duration: 2 hrs

Due to: Cerebral Sclerosis + Valvular Heart disease — 20 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Culverhouse M. D.
Address 1901 Eutaw Pl Date signed 1/28/44

VS 180

13465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13465
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Balto.
(c) City or town TOWSON 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 E. PENNSYLVANIA AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WARREN ALLEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 17, 1886

8. AGE: Years	Months	Days	If less than one day
57	10	20	hr. min.

9. Birthplace NEW YORK, NEW YORK
(Town, county, and state)

10. Usual Occupation BUSINESS

11. Industry or business BLACK + DECKER CO.

FATHER
12. Name THOMAS ALLEN
13. Birthplace ENGLAND

MOTHER
14. Maiden Name BELLA M. CHAPEL
15. Birthplace NEW YORK NEW YORK

16 (a) Informant Hospital Records
(b) Address Union Memorial

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director John Burns, Sons
(b) Address Towson, Md.

JAN 29 1944 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 27 1944 at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 15 1944 to JAN. 27 1944 and that I last saw HIM alive on JAN. 27 1944.

Immediate cause of death CARDIAC FAILURE — Duration

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE — 5 yrs (C)

Due to

Other Conditions Acute pulmonary edema, ct. hemiplegia.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Hungerford Jr. M. D.
Address 332 E. University Pkwy. Date signed 1/27/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C 13466

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 N. C Cullob
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 N. C Cullob
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Chanie

3 (b) If veteran, name war ~

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) —

8. AGE: Years: 92 | Months | Days | If less than one day: hr. min.

9. Birthplace Charlottsville Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Vernon Carey

13. Birthplace Charlottsville Va

MOTHER 14. Maiden Name Mildred?

15. Birthplace Va Va

16 (a) Informant Walter B Bagley

(b) Address 1802 N. C Cullob

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk

Location Arbutus Md

18 (a) Funeral director Robert E Williams

(b) Address 1515 McElderry St

19 (a) JAN 29 1944 (Date rec'd by registrar) (b) Huntington Hill Baltimore, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1944 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1943 to Jan 26 1943 and that I last saw h alive on Jan 26 1943

Immediate cause of death — Duration

Due to Apoplexy 1 day

Due to Arterio-Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Edward Fisher M. D.

Address 2 E Monument Date Jan 27 1944

VS 180

G 13467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G 13467 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Aves.
(c) Hospital or institution:
St. Agnes 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 140 days
(e) Length of stay in Baltimore (yrs., mos., or days) " "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 1st Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter W. Carroll Millholland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age 5 years

7. Birth date of deceased (mo., day, yr.) May 5, —

8. AGE: Years	Months	Days	If less than one day
59	--	-	— hr. — min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation Parent
11. Industry or business

FATHER
12. Name Dr. Edw. T. Millholland
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Collins
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 1/31/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) JAN 29 1944 (Local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 127-44 19 at 6.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1943 to 1-27 1944 and that I last saw h. M alive on 1-27-44 19

Immediate cause of death Chronic Myelogenous Leukemia — **Duration**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D.
Address St. Agnes Hospital Date signed 1/29/44 M. D.

Correct age as expressly important. Physicians: please write the causes of death clearly and legibly.

13468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 13468

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days.
(e) Length of stay in Baltimore (yrs., mos., or days) about 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2841 Parkewood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Mc Clenahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Harry J. McClenahan
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) ---------

8. AGE: Years	Months	Days	If less than one day
About 65	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Francis J. Valentine
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary R. Podesta
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Katherine T. Valentine
(b) Address 1120 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert Street

19 (a) JAN 29 1944 (Date rec'd by Registrar) (b) Huntingdon Pennsylvania, M.P. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1944 at 4 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5-44 19 to 1-27 1944, and that I last saw her alive on 1-27 19 44

Immediate cause of death Cerebral Hemorrhage — Duration 19 dy

Due to Hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roberts B. MacDonald M. D.
Address 1213 Light St Date signed 1-27-44

VS 8

G 13469
JL - 37589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D ✓

G 13469 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 3 - 22
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 749 Wilmer Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Sorrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Sadie (Sep.)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1877

8. AGE: Years	Months	Days	If less than one day
66	2	0	hr. min.

9. Birthplace N. J. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Edward Sorrell
13. Birthplace Md.
14. Maiden Name Emma
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/44 (Month) (Day) (Year)
(c) Cemetery or crematory Pacific Memorial Park
Location Harman & Fire Road

18 (a) Funeral director J. J. Tobey Rogers
(b) Address 201 E. Light St. Huntington, Baltimore, Md.

19 JAN 30 1944 (Date rec'd by registrar)

Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1944 at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1944 to 1/23 1944 and that I last saw him alive on 1/23 1944

Immediate cause of death: Cerebral thrombosis — Duration 7 d.

Due to A S C V D

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sargeon M. D.
Address B C H Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 13470
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 Aldershot Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Aldershot Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Goetter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color of race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Virginia Goetter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1873

8. AGE: Years	Months	Days	If less than one day
70	7	30	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name	Valentine Goetter
FATHER 13. Birthplace	Germany
MOTHER 14. Maiden Name	Unknown
MOTHER 15. Birthplace	Md

16 (a) Informant Mrs. Joseph Goetter
(b) Address 629 Aldershot Road
17 (a) burial (b) Date thereof 1/31/44.
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Longwood & Edmondson Ave
18 (a) Funeral director John J. Conway & Son
(b) Address 900 Pulteney Street
19 (a) (b) Hunterstown, Pa.
(Signature of registrar)

JAN 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28, 1944, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1943 to Jan 28 1944 and that I last saw him alive on Jan 27 1944.

Immediate cause of death: Cardio-Vas.-renal Disease — Duration 7 Hrs

Due to

Due to

Other Conditions: Spondalitis Deformans
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. P. Von Schrenk M. D.
Address 818 Edmondson Ave Date signed Jan 28, 1944

13471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 13471 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 E 32nd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 69 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 E 32nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Guyton Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-5645

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Sarah L. Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19/1874

8. AGE: Years 69 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Night clerk

11. Industry or business Tudor Gate Apts

FATHER 12. Name Charles R Coleman
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Eleanora Guyton
15. Birthplace Baltimore Md

16 (a) Informant Preston Hayes Coleman
(b) Address 5332 Cordelia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 31/1944
(month, day) (year)

(c) Cemetery or crematory Loudon Park.
Location Baltimore Md.

18 (a) Funeral director Harry R. Annacost
(b) Address 4204 Ridgewood Ave

JAN 30 1944 (Date received by Registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28/1944 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1/1943 to 1/28/1944 and that I last saw him alive on 1/26/1944

Immediate cause of death: Myocardial degeneration — Duration 1 yr.

Due to: Arteriosclerosis — Duration 5 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. J. Freeman M. D.

Address 1710 E 32nd St Date signed 1/29/44

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13472 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Jan. 26, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Whitman (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Hershey (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME EPHRIAM LINWOOD TRIPP

3 (b) If veteran, name war
3 (c) Social Security Account No. 961-10-9009

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/15/1898
8. AGE: Years 45 | Months 10 | Days 13 | If less than one day hr. min.
9. Birthplace Fair Haven, Mass. (Town, county, and state)
10. Usual Occupation Boatswain
11. Industry or business Merchant Marine

FATHER
12. Name Ephriam P. Tripp
13. Birthplace Fair Haven, Mass.

MOTHER
14. Maiden Name Jennie Tilton
15. Birthplace Grand Rapids, Michigan

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/29/44 (month) (day) (year)
(c) Cemetery or crematory Riverside Cem. Location Fairhaven, Mass

18 (a) Funeral director Wm. J. Dickens & Sons
(b) Address Balto., Md.

19 (a) (registrar) (b) Huntington Williams, M.D.

JAN 30 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1944, at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26, 1944, to Jan. 28, 1944, and that I last saw him alive on Jan. 28, 1944.

Immediate cause of death: Pneumonia, bilateral — Duration: 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Adams M. D.
Address Baltimore, Md. Date signed 1/28/44

MS-50667

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 13473 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Woodridge Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK B. LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Dorothy M. (nee) McCarthy 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23-1902

8. AGE: Years	Months	Days	If less than one day
41	6	4	hr. min.

9. Birthplace Washington N.C. (Town, county, and state)

10. Usual Occupation Supervising Engineer
11. Industry or business

FATHER
12. Name Frank B. Lewis
13. Birthplace N.C.

MOTHER
14. Maiden Name Lassie Roberts
15. Birthplace N.C.

16 (a) Informant Mrs. Dorothy M. Lewis
(b) Address 3908 Woodridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Hallstown
Location Quincy, Mass.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) [illegible] (b) [illegible] Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION 10 A.

20. DATE OF DEATH January 27, 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis.
Arteriosclerotic basis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 1-28-44

G 13474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13474 Registered No. 520

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Aves
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 117 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3822 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward John Naffel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha A. Guckert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 30 - 87

8. AGE: Years	Months	Days	If less than one day
56	-	28	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Clerk B.O.R.R.

11. Industry or business

FATHER
12. Name John Naffel
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Koertner
15. Birthplace Md

16 (a) Informant Mrs. Bertha A. Naffel
(b) Address 3822 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 - 31 - 44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruske
(b) Address 3305 Hayford Road

JAN 30 1944 (Date filed by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1944, at 2 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1943, to Jan. 28 1944, and that I last saw him alive on Jan 27 1944.

Immediate cause of death Cachexia — Duration

Due to Compression Paraplegia 3-7th Thoracic Vertebrae

Due to Metastases from Hypernephroma, Lft. Kidney

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Luther Rosenberg M. D.

Address St. Agnes Hosp. Date signed 1/28/44

VS 150

G 13475

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 13475

CERTIFICATE OF DEATH 13 a

Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 S Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 S. Charles St (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Agnes Smith.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Wm. J. Smith

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1879

8. AGE: Years 64 | Months 1 | Days 3 | If less than one day: hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Leven S. Hubbard
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Lewis
15. Birthplace Md.

16 (a) Informant Mr. Edwin L. Smith
(b) Address 132 E. Ostend St. (Son)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. A. Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Chase St. Balto. 3, Md.

19 (a) Jan 31 1944 (b) [illegible] registrar [illegible]

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1944, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1943 to Jan 28, 1944, and that I last saw her alive on 28 Jan 1944.

Immediate cause of death: Cardio-vascular Renal disease — Duration: 15 Yrs.

Due to Chronic Myocarditis

Due to with Cardiac decompensation — 3 Yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph N. Zierler, M. D.
Address 918 Eutaw Place Date signed 1/31/44

G 13476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13476 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 E. Randall
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 5-5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 E. Randall (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Ida M. Allen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John E. Allen

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 2 1874

8. AGE: Years 69 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Cockeysville Md. (Town, County, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Wm. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Simms
15. Birthplace Md.

16 (a) Informant Edward L. Allen (Son)
(b) Address 3315 Parkhurst Ave.

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof Feb 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore, Md.

18 (a) Funeral director C. A. Howard Evans
(b) Address 1400 N. Charles St. Balto, 30, Md.

19 (a) — (Undertaker) (b) Huntingtor Williams Md

JAN 30 1944

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29, 1944 at 12:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1943, to 1-29 1944, and that I last saw her alive on 1-29 1944.

Immediate cause of death: Chronic Myocardial Degeneration

Due to Arteriosclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration
1 yr.
2 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. Ballard M.D.
Address 7075. Font Ave. Date signed 1-29-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G 13477

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 W. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Brent

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	–

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Wytheville Va.
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name James W. Brent
13. Birthplace Staunton Va.

MOTHER
14. Maiden Name Cornelia Davis
15. Birthplace Va.

16 (a) Informant James A. Brent
(b) Address 1137 Penna Ave

17 (a) Burial (b) Date thereof 1/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Camden N.J.

18 (a) Funeral director A. Hall Dent
(b) Address 917 Druid Hill Ave

19 (a) 30994 (Date filed by registrar) (b) Hunting on Public Highway

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28- 1944, at 9:40 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions Injury to trophy of Diaphragm
7 Hours
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 1-29-44

G 13478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13478
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 E. Lorraine
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. Lorraine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice N. McCauley

3 (b) If veteran, name war W
3 (c) Social Security Account No. NONE

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bernard J. McCauley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 - 1870

8. AGE: Years 73 | Months 9 | Days 3 | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George H. Holmes
13. Birthplace Unknown

MOTHER
14. Maiden Name Sophronia Johnson
15. Birthplace Va.

16 (a) Informant Bernard J. McCauley
(b) Address 313 E. Lorraine Ave

17 (a) Burial (b) Date thereof 2/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Chester
Location Chestertown Md.

18 (a) Funeral director Wilson & Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JAN 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 - 1944 at 6 02 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1943 to Jan 29 1944.
and that I last saw her alive on Jan 24 1944.

Immediate cause of death: Bronchial Pneumonia — Duration: 1 week
Due to
Due to Cirrhosis — Duration: yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 900 Harrison Date signed 1/29/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Huntington Williams, M.D.

G 13479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13479 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Magaw

3 (b) If veteran, name war No
3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary E. Magaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5th 1864

8. AGE: Years 79 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Self

FATHER
12. Name Magaw
13. Birthplace (Not Known)

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Ethel Dobson
(b) Address 2518 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. - Extended

18 (a) Funeral director Williams Cook Inc
(b) Address 127 W. St. Paul St

19 (a) (Signature of registrar) (b) Registrar

JAN 31 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29th 1944 at 6:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 43 to Jan 29 19 44
and that I last saw h alive on Jan 29 19 44

Immediate cause of death Chronic Myocarditis
Due to
Due to
Other conditions Senile Debility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: Chronic Myocarditis many yrs; Senile Debility ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Nelson MD
Address 17 W. 25th St Date signed Jan 29, 44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13480 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2709 Grindon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Grindon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank C. Sandner

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, ~~married, widowed, or divorced~~? Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 4th 1875

8. AGE: Years 68 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Carpenter

FATHER 12. Name Louis S. Sandner

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Kissner

15. Birthplace Balto. Md.

16 (a) Informant John H. Sandner

(b) Address 2709 Grindon Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/31/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto

Location " Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St

19 (a) 30 1944 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28th 1944 at 10:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1944 to Jan 28 1944 and that I last saw him alive on Jan 25 1944.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension (Essential)

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sampson M. D.

Address 4808 Harford Rd. Date signed 1/28/44

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13481 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 N. Pearl Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boyce F. Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-1810

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Marion M. Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20th 1880

8. AGE: Years	Months	Days	If less than one day
63	2	8	hr. min.

9. Birthplace Wilks Co. Ga.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Novak Construction Co.

FATHER
12. Name (Unknown) Bailey
13. Birthplace Va.

MOTHER
14. Maiden Name Victoria Patterson
15. Birthplace Va.

16 (a) Informant Mrs. Marion Bailey
(b) Address 121 N. Pearl St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1218 St. Paul St. ~~Washington Boulevard~~

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28- 1944, at 8 P. M

21. I certify that I took charge of the remains described above, held an ~~Autopsy~~ Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiac - Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 1-29-44

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G 13482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13482 Registered No. 161B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Dihedral Drive, Middle River (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford Eugene Smith

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No BE

4. Sex: M | 5. Color or race: W | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 16th 1944

8. AGE: Years | Months | Days: 12 | If less than one day: hr min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Hiram E Smith
13. Birthplace New Mexico

MOTHER
14. Maiden Name Janie Daniel Wilson
15. Birthplace Alabama

16 (a) Informant mother
(b) Address

17 (a) Burial (b) Date thereof 1/31/44 (month) (day) (year)
(Burial, ~~cremation~~, or ~~removal~~)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1944, 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1944, 12:15 AM to Jan 28 1944, 9:45 PM, and that I last saw him alive on Jan 28 1944.

Immediate cause of death: Respiratory failure — Duration
Due to: Septicemia
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. Gwyther
Address Mercy Hosp Date signed 1/31/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 13483 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 S. London Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 S. London Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Louis Potee

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Katherine Potee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25th 1883

8. AGE: Years	Months	Days	If less than one day
60	8	3	hr. min

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Schenkhild Kohn Co

FATHER
12. Name George Potee
13. Birthplace Md.

MOTHER
14. Maiden Name A Kenny
15. Birthplace Ireland

16 (a) Informant Mrs Katherine Potee
(b) Address 121 S. London Ave

17 (a) Burial (b) Date thereof 1/31/44 (month) (day) (year)
(Burial, ~~cremation, or removal~~)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 127 St. Paul St

19 (a) (Date rec'd by registrar) Livingston Williams, Registrar

JAN 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28th 1944, at 3:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1939 to Jan 28 1944, and that I last saw h in alive on Jan 28 1944.

Immediate cause of death Hemorrhage Pulmonary
Due to Tuberculosis Pulmonary Bilateral
Due to
Other Conditions

Duration: Pulm 6 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Elliot W Johnson
Address 2432 Druid Hill Ave Date signed 1/28/44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13484 ✓ G 13484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1623

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1546 Ausgusta St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1546 Ausgusta St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Hepburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hattie V. Hepburn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1868

8. AGE: Years 75 | Months 5 | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore Co. Md (Town, county, and state)

10. Usual Occupation Plaster

11. Industry or business

MOTHER / FATHER

12. Name William Hepburn

13. Birthplace Baltimore Co.

14. Maiden Name Nancy Barry

15. Birthplace Baltimore Co. Md

16 (a) Informant Mrs. Hattie V. Hepburn

(b) Address 1546 Ausgusta St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Eo

18 (a) Funeral director Edwin W Conkling Son

(b) Address 2242 Eastern Ave

19 (a) Feb 1 1944 (Date rec'd by registrar) (b) Huntingtown Prince Georges, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27, 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1940, to Jan 27 1944, and that I last saw him alive on 26 Jan 1944.

Immediate cause of death Marked Emaciation & Infirmities of age

Due to age

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. Perry Carman M.D.

Address 1701 N. Carolina Date signed Jan 28 1944 Feb 1 1944

M. D.

VS 3

G 13485 G 13485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. Beckley Springs W. Va (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Jacob Y. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Home Work

FATHER
12. Name Noah Hirsch
13. Birthplace Russia

MOTHER
14. Maiden Name Gertrude Schapiro
15. Birthplace Russia

16 (a) Informant Jacob Y. Miller
(b) Address Beckley Springs W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) Jan 30 1944 (Date received by Registrar) (b) Theodore J. Von Paschen, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29 1944 at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1944 to 1-29 1944, and that I last saw her alive on 1-29 1944.

Immediate cause of death Heart Failure — Duration
Due to Hypertensive Heart Disease
Due to
Other Conditions Diabetes Mellitus Arteriosclerotic H. Dis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D. Hirsch M. D.
Address Sinai Hosp Date signed 1-29-44

G 13486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13486 Registered No. 232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2039. Mc Culloh
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2039. Mc Culloh
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME H. Tyler Coleman. M. D.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	M

6 (b) Name of husband or wife Veola. G. Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20-867

8. AGE: Years	Months	Days	If less than one day
76	3	7	hr. min.

9. Birthplace Uniontown Ala
(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name John R. Coleman
13. Birthplace Va

MOTHER
14. Maiden Name Mary Glascoe
15. Birthplace Va

16 (a) Informant Veola. G. Coleman
(b) Address 2039. Mc Culloh

17 (a) Burial (b) Date thereof 1-30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Sam'l. F. Chase Inc
(b) Address 638. N. Gilmor St

19 (a) (Date received by registrar) (b) Registrar

JAN 30 1944 Registered No. 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1944, at 10:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1943, to Jan 26 1944, and that I last saw h[illegible] alive on Jan. 25 1944.

Immediate cause of death Coronary Occlusion — Duration

Due to Influenza

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Shepherd M. D.
Address 601 W Franklin St Date signed 1/29/44

G 13487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G 13487 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4805 Keswick Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4805 Keswick Road
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME David Arthur

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Elizabeth Duff
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1891

8. AGE: Years	Months	Days	If less than one day
52	11	16	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Ford Brooklyn Motors

FATHER
12. Name David Hinkle Arthur
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ella C. Mopps
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary Elizabeth Arthur
(b) Address 4805 Keswick Road

17 (a) Burial (b) Date thereof 1/31/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) JAN 30 1944
(Date rec'd by registrar) Registrar for William Register

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1944 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to Jan 28 1944, and that I last saw h alive on Jan 27 19 ....

Immediate cause of death
Lung Abscess
Due to .....
Due to .....
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: one
of autopsy: .....

Duration
5 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Evans M. D.
Address 6 E 24 St Date signed .....

G 13488 G 13488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 498

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 534 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [illegible]
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Regenia Kane

3 (b) If veteran, name war --

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Wht.	Married

6 (b) Name of husband or wife Wm. J. Kane
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1863

8. AGE: Years	Months	Days	If less than one day
81	-	18	..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business --

FATHER
12. Name ? Higgiston
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant J. Morita
(b) Address 1407 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 31, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

JAN 30 1944 (Date rec'd by registrar) [illegible] Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1944, at 12.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16- 1944 to 1-29- 1944, and that I last saw h[illegible] on 1-29- 1944.

	Duration
Immediate cause of death Acute Cardiac Dilatation	3 [illegible]
Due to Myocarditis Chronic	2 yrs.
Due to Arteriosclerosis General.	2 yrs.
Other Conditions Carcinoma Uteri. general, Nephritis.	2 yrs.

(Include pregnancy within 3 months of death)
Date of operation [illegible]
Major findings of operation: [illegible]
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 516 Cathedral Date signed 1-29- 1944

G 13489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 330

G 13489 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 N. Mount St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virgie May Jackson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	F	C	Married

6 (b) Name of husband or wife Happy
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 4/20/1896

8. AGE: Years	Months	Days	If less than one day
47	9	6	hr. min.

9. Birthplace Merton Montgomery Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth Snowden
15. Birthplace Md.

16 (a) Informant Harry R. Jackson (Husband)
(b) Address 303 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/44 (month) (day) (year)
(c) Cemetery or crematory Rocky Hill Cem.
Location Clarksburg, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

1/30 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26/44 19 , at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1944 to Jan 26 1944 and that I last saw her alive on Jan 25 1944

Immediate cause of death Acute Myocarditis — Duration 6 days

Due to Pleurisy and Bronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. T. Gunnar M. D.
Address 522 N. Arlington Ave Date signed 1/29/44

G 13490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13490 Registered No. 161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3615 E. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl N. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Wm. H. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23-1874

8. AGE: Years	Months	Days	If less than one day
69	3	4	hr. min.

9. Birthplace Kasson, Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Joshua Riley
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Lane
15. Birthplace Pa.

16 (a) Informant Wm. H. Jones
(b) Address 3615 E. Lombard St.

17 (a) Burial (b) Date thereof Jan. 30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Poplar Grove
Location Kasson, Balto. Co. Md.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) (b)
(Signature of registrar)

JAN 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1944 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/13 1943 to 1/27 1944 and that I last saw h[illegible] alive on 1/27 1944.

Immediate cause of death Cardio-vascular renal disease — Duration

Due to A. Nephritis

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3215 Eastern Ave. Date signed

JO #85160 G 13490

BALTIMORE CITY HEALTH DEPARTMENT G 13490

CERTIFICATE OF DEATH 1312

Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 26 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Naomi Fleming (Nee Roselle)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Bruce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1916

8. AGE: Years	Months	Days	If less than one day
27	4	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Rosell
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie ?
15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Signature of registrar) (b) Registrar

JAN 30 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1943 to 1/26 1944, and that I last saw h alive on 1/26 1944.

Immediate cause of death Pulmonary tuberculosis

Duration
2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 1/28/44 M. D.

G 13492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G 13492 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5201 Linden Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 Linden Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Saverio Gugliuzza

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife late Carmela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Cefalu' Italy
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Pasquale Gugliuzza
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Charles Gugliuzza (Son)
(b) Address 5201 Linden Heights Ave

17 (a) Burial (b) Date thereof Jan. 31 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balt. Md.

18 (a) Funeral director Frank Dallas Mace
(b) Address 52 N. Morley St. Whitmore, Md.

JAN 31 1944 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1944 at 11 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1944 to 1/27 1944
and that I last saw h~~im~~ alive on 1/27 1944

Immediate cause of death Carcinoma of rectum ?
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Roberta A. Reitz
Address 3408 Windsor Ave Date signed 1/28/44

13493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13493

Registered No. 122B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira St. & Fondren Ave
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (~~year, month~~ days) 2 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Taft St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Benjamin Shaffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1937

8. AGE: Years	Months	Days	If less than one day
6	10	25	hr. min.

9. Birthplace Harford Co. Md
(Town, county, and state)

10. Usual Occupation School boy

11. Industry or business None

FATHER
12. Name Harvey Shaffer
13. Birthplace Butler Co. Penna

MOTHER
14. Maiden Name Florence Co. Penna
15. Birthplace Lancaster Co. Penna

16 (a) Informant Harvey Shaffer
(b) Address Aberdeen Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1 1944
(month) (day) (year)

(c) Cemetery or crematory Dublin Cem.
Location Harford Co. Md.

18 (a) Funeral director H. B. Bailey
(b) Address Darlington Md.

19 JAN 31 1944 (b) Hunting for Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1944 at 2.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1944 to 1-30 1944.
and that I last saw ~~him~~ alive on 1-30 1944.

Immediate cause of death: Intestinal Obstruction — Duration: 4 days
Due to Post. op. adhesions
Due to
Other Conditions Bronchopneumonia
(Include pregnancy within 3 months of death)

Major findings:
Of operations Intestinal Obstruction due to post. op. adhesions
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jackson D. Young Jr. M. D.
Address Md. Gen. Hosp. Date signed 1-30-44

VS 3

FAILURE WITH FOUND, WITH ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

G 13494 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 Wheeler Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Samuel P
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4 88 A

8. AGE: Years	Months	Days	If less than one day
55	4	26	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Zehe
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline
15. Birthplace Germany

16 (a) Informant Samuel P Allen
(b) Address 21 N Wheeler Ave
17 (a) Burial (b) Date thereof 2-2-44 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Lorraine
Location Loch Raven Blvd
18 (a) Funeral director George A Fuller
(b) Address Linton & Fayette
19 JAN 31 1944 Huntington Hillsdale Md
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1944 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29 1944 to 1/30 1944 and that I last saw h[illegible] alive on 1/30 1944.

Immediate cause of death Uraemic Coma — Duration

Due to Terminal stages of chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M.D.
Address St Agnes Hosp Date signed 1/30/44

13495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. C 13495

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Reservoir St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Reservoir St
(If rural give location)
(e) Citizen of foreign country? , Yes or No)
If yes, name country

3 (a) FULL NAME William Howard Schweizer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Juliet S. Schweizer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3rd 1883

8. AGE: Years	Months	Days	If less than one day hr.	min.
60	11	25		

9. Birthplace Feb 3rd 1883
(Town, county, and state)
10. Usual Occupation Mechanical Engineer
11. Industry or business Self

FATHER
12. Name Charles Schweizer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Edna Gill
15. Birthplace Unknown

16 (a) Informant Juliet S. Schweizer
(b) Address 701 Reservoir St

17 (a) Burial (b) Date thereof 1/31/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Greenmount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 JAN 31 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28th 1944, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1943 to Jan 28 1943.
and that I last saw him alive on Jan 25 1943.

Immediate cause of death	Duration
Pulmonary Embolism	—
Due to Cirrhosis of Liver with ascites	6 yrs.
Due to	
Other Conditions Chronic valvular Heart Disease (Include pregnancy within 3 months of death)	4 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard H. Schweizer M. D.
Address 2020 N. Charles Date signed 1/30/44

13496

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

(1) 93D

Registered No. G 13496

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5014 Norwood Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Francis Buchal

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years	Months	Days	If less than one day
64-65			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name Herman Buchal
13. Birthplace Germany

MOTHER
14. Maiden Name Grace Eyle
15. Birthplace Germany

16 (a) Informant Mrs P.L. Buchal.
(b) Address 5014 Norwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory Cedselve
Location Ref Federal Rd

18 (a) Funeral director Fahey & Spare
(b) Address 1218 Light St.

19 (a) JAN 31 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1944, at 6:45 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to Hypertension Cardiovascular disease

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed January 30 1944

correct age is especially important. Physicians: please write the cause of death in plain English—avoid technical terms.

VS 151

13493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(3) 92B

G 13497
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway • Fairmount Ave
(c) Hospital or institution: Church Home and Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 W. Lafayette
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Henry Robins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	[redacted] Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/16/[illegible]

8. AGE: Years	Months	Days	If less than one day
39	4	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business

FATHER
12. Name Joseph Henry Robins
13. Birthplace Canada

MOTHER
14. Maiden Name Irene Busch
15. Birthplace Baltimore

16 (a) Informant Mrs Irene Robins
(b) Address 637 Baker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Pasadena Md.

18 (a) Funeral director J. J. Fleig Sons
(b) Address 1 E. Lexington St

19 JAN 31 1944 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1944 at 7 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1944 to 1-28 1944 and that I last saw h[illegible] alive on 1-27 1944.

Immediate cause of death	Duration
? cerebral embolus	0
Due to Auricular fibrillation	> 21 days
Due to Rheumatic Heart Disease	27 yrs
Other Conditions Asthma	1½ yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of [illegible] Mitral stenosis
Thrombi in both auricles; Lung infarcts
of autopsy: ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isabella Harrison M. D.
Address Church Home & Hosp Date signed 1-28-44

VS 150

13498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

G 13498 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Jan. 26, 1944 12 M
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 N. Dallas Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH SYLVESTER BLANK

3 (b) If veteran, name war SP. AMERICAN

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/79

8. AGE: Years 64 | Months 0 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation PO - 1 yr ago Laborer

11. Industry or business

FATHER
12. Name Joseph Blank
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Fix
15. Birthplace Germany [illegible] Pa.

16 (a) Informant Mr. Edward Blank [illegible]ital
(b) Address 1931 Grinnalds Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 JAN 31 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Jan. 28, 1944, at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26, 1944, to Jan. 28, 1944, and that I last saw him alive on Jan. 28, 1944.

Immediate cause of death 1. Diffuse marked edema and congestion of both lungs with purulent bronchitis. 2. Dilatation of the right side of the heart. — Duration: Bet. days Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. S. Blank

Address Baltimore, Md. Date signed 1/28/44 M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Va-14262

13499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G 13499
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2010 E. 31st St.
(c) Hospital or institution: 9416

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 E. 31st St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE CHRISTINE FREDERICK

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Divorced

6 (b) Name of husband or wife Charles Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1862

8. AGE: Years	Months	Days	If less than one day
81	1	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name George Frederick
13. Birthplace Germany

MOTHER 14. Maiden Name Caroline Stahl
15. Birthplace Maryland

16 (a) Informant Mrs. Burt B. Ide
(b) Address 2010 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director H. SANDER & SONS, INC.
(b) Address North Ave. & Broadway

JAN 31 1944 (Date rec'd by registrar) (b) Huntington Hill, Registrar

VS 250

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH January 27 1944 at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 'ee 19 44 to Jan 27 19 44 and that I last saw deceased alive on Jan 26 19 44

Immediate cause of death — Duration

Acute Cardiac Dil. — 3 days

Due to

Due to Chr. Valvular Heart Disease — 2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G W Ide M.D.
Address 1501 E 31st Date signed Jan 28 1944

13500

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G 13500

CERTIFICATE OF DEATH 9 | a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 9 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Somerset
(c) City or town Rural Dames Quarter (If outside city or town limits, write RURAL and give town)
(d) Street No. Rural Dames Quarter (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen E Ford (HELEN ELIZABETH FORD) ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Woodal Ford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) not known May 22 1894

8. AGE: Years 49 2 | Months 8 | Days 9 | If less than one day: hr. min

9. Birthplace Dames Quarter Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER
12. Name William Mc Dorman
13. Birthplace Dames Quarter, Md.

MOTHER
14. Maiden Name Mary Lorette Parks
15. Birthplace Chance Md

16 (a) Informant Mrs Charles E Simpkins
(b) Address not known

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1. 1944 (month) (day) (year)
(c) Cemetery or crematory Dames Quarter Cem.
Location Dames Quarter, Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway.

19 (a) JAN 31 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1944 at 6.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 .
and that I last saw h alive on 19 .

Immediate cause of death
respiratory failure

Due to meningitis

Due to pneumococcus Type 19

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 1-30-44

Correct age is especially important. Physicians: please write the exact number of years and days.

G 13501 — 3 — 1944

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 13501 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 S. bouldin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME (MARY ROSE DIETZ

3 (b) If veteran, name war no

3 (c) Social Security Account No. 212-09-0954

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas Dietz

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 8, 1885

8. AGE: Years 58 | Months 7 | Days 21 | If less than one day: hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business I. C. Isaac & Co.

FATHER
12. Name Henry Seidling
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Beck
15. Birthplace Germany

16 (a) Informant Wilbert Rejzek (Son)
(b) Address 415 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Feb. 1. 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 JAN 31 1944 (Date received by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29-1944 at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27-1944 to 1-29-1944 and that I last saw her alive on 1-29-1944

Immediate cause of death Bilateral Lobar Pneumonia — **Duration** 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Olzesberg, M. D.
Address Church Home Hospital Date signed 1/29/44

VS 150

G 13502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13502 ✓ Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Eight St.
(c) Hospital or institution: South Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Light House Hotel (If rural give location)
(e) Citizen of foreign country? 20 E. Canada (Yes or No)
If yes, name country

3 (a) FULL NAME Howard BAILEY ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8

8. AGE: Years	Months	Days	If less than one day hr.	min.
46				

9. Birthplace Romney W. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thornton Bailey
13. Birthplace W. Va.

MOTHER
14. Maiden Name Della Parr
15. Birthplace W. Va.

16 (a) Informant Pearl Kopage
(b) Address 1402 Patterson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patt Park Ave

19 (a) 1944 (b) [illegible] for Williams M.D. Registrar
(Date of registration)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25, 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944 to Jan 31 1944, and that I last saw h[illegible] alive on Jan 21 1944.

Immediate cause of death	Duration
Lobar pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Williamson M. D.
Address South Post Office Date signed 1-21-44

19 03

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

✓ G 13503 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 18 B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min. 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? ? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Bareuskas

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 215-03-0003

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 62 ? Months ? Days ? If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 / 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Beard Rd

18 (a) Funeral director Joseph Kaunakas Sons
(b) Address 608 E. Washington Blvd

JAN 31 1944 (b) Hunting for Williams M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1944, at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29 1944 to 1/30 1944. and that I last saw h[illegible] alive on 1/30 1944.

Immediate cause of death Pulmonary TBC; Meningitis — Duration ?

Due to B.P.H. c acute miliary tuberculosis — ?

Due to

Other Conditions Hem. cyteno - sclerosis; cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M.D.

Address BCH Date signed 1/30

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 48a

G 13504
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 McCulloh St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estelle Lufa Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24 1879

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64	4	6		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name John Brown
13. Birthplace Va

MOTHER
14. Maiden Name Harriet Saunders
15. Birthplace Md

16 (a) Informant Mrs Josephine Jackson
(b) Address 2009 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-44 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem
Location Baltimore Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

JAN 31 1944 (Date received by registrar) Huntington Williams Asst. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1944 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/28 19 44 to 1/30 19 44.
and that I last saw h alive on 1/30 19 44

Immediate cause of death
Congestion
Cerebral Coma
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy Thetta M. D.
Address 2939 Druid Hill Ave. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117B

Registered No. G 13505

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Truss
(c) Hospital or institution:
University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 570 Presstman Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Rice

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Nelta Rice
13. Birthplace Va

MOTHER
14. Maiden Name Hattie Fields
15. Birthplace Va

16 (a) Informant Wm. Haines
(b) Address 570 Presstman Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto Md.

18 (a) Funeral director Wm. F. Haines & A. Hensky
(b) Address 574 W. Pratt, Balto Md.

19 JAN 31 1944 (b) Huntington Indiana
(Filed 10 days after death) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1944, at 6 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..... to 19..... and that I last saw h alive on 19.....

Immediate cause of death	Duration
Cardiac Dilatation	
Due to Pneumonia	
Due to Ruptured duodenal ulcer	?
Other Conditions Bilateral Lemonkyitis plural effusion	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: See above
of autopsy: See above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. V. Palmer M. D.
Address University Hospital Date signed 1/29/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G 13506 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 207 S. Gilmor St

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —19

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 207 S. Gilmor St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marie E. Randle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Late Herbert E. Randle

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 14 - 1888

8. AGE: Years	Months	Days	If less than one day
55	8	13	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER

12. Name Nathan Ellis

13. Birthplace Md

MOTHER

14. Maiden Name Hankin

15. Birthplace Md

16 (a) Informant Mr. Lester Randle

(b) Address Lauretta Ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 2-1-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Geo L. Berger Jr

(b) Address 1900 Hollins St

19 JAN 31 1944 (Date rec'd by registrar) **(c)** Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1944, at 11:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1944 to Jan 27 1944 and that I last saw him alive on Jan 27 1944

Immediate cause of death	Duration
Acute Myocarditis	hours days
Due to Toxemia of Pregnancy	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Thorsen M. D.

Address 404 Edmondson Ave Date signed

VS 180

SOWERS

13507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 13507
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. City Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 Biddle St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Allen Nelson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Washington D. C.
(Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name Not known
13. Birthplace

MOTHER
14. Maiden Name Not known
15. Birthplace

16 (a) Informant Alfred Hicks
(b) Address 340 Biddle St

17 (a) Burial (b) Date thereof 7-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. G. Lee Md.
18 (a) Funeral director M/P Frances A. Hensley
(b) Address 578 W. Biddle St
19 (a) (b) Huntington Williams, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/28/44 19 4 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 6/28/44 to 6/28/44, and that I last saw him alive on 6/28/44.

Immediate cause of death Bronchopneumonia — Duration 3 days
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. C. Lee M. D.
Address 424 Mad Ave Date 6/29/44

VS 150

This information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13508 St. Paul St
Dr. Jones.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13508
Registered No.

8212

The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3628 Keswick Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3628 Keswick Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Witz.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Mary Irene Witz
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1863

8. AGE: Years 80 | Months 4 | Days 12 | If less than one day: hr min.

9. Birthplace Pennsylvania (State, county, and state)
10. Usual Occupation Retired
11. Industry or business Engr & Conductor Ga. R.R.

MOTHER / FATHER
12. Name Unknown
13. Birthplace Unknown
14. Maiden Name Mary Witz.
15. Birthplace Pa.

16 (a) Informant Mary Irene Witz.
(b) Address 3628 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31/44 (day) (month) (year)
(c) Cemetery or ~~crematory~~ Western
Location Edmondson Ave

18 (a) Funeral director Johnson & Donovan
(b) Address 3615 Eastern Ave.

19 (a) JAN 31 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1944, at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1943 to Jan 28 1944, and that I last saw h alive on Jan 28 1944.

Immediate cause of death: Arteriosclerosis Cerebral thrombosis — Duration: 15 yrs 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H G Jones M. D.
Address 2818 N Charles Date signed 1/31/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

3509

~~[illegible]~~ 47383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G 13509

Registered No. 120 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Usual address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Rochester (If outside city or town limits, write RURAL and give town)
(d) Street No. 366 Kilbourn Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Halle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Charles Halle
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 3-20-05

8. AGE: Years 39 | Months 10 | Days 10 | If less than one day: hr min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation R.N.

11. Industry or business

FATHER
12. Name Harry Leiter
13. Birthplace N.Y.

MOTHER
14. Maiden Name Franc Handsbery
15. Birthplace N.Y.

16 (a) Informant
(b) Address ~~ELLISON SUPPLY SHOP~~

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)

(c) ~~Cemetery or~~ crematory London Park
Location 3801 Frederick Ave.

18 (a) Funeral director Leland, Mitchell & Long, Inc.
(b) Address 900 Eutaw Place

19 JAN 31 1944 (Date rec'd by registrar) (b) Huntington, West Virginia (Clerk or Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1944, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Jan 1944, to 30 Jan 1944, and that I last saw her alive on 30 Jan 1944.

Immediate cause of death Generalized Peritonitis. — Duration

Due to Perforation of Colon.

Due to Ulcerative Colitis.

Other Conditions Perirectal Abscess.

(Include pregnancy within 3 months of death)

Date of operation 1-14-44

Major findings of operation: Thickened chronically inflamed colon.

of autopsy: Generalized Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul W. Saunders
Address [illegible] Date signed 1/30/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13510
JL - 64707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 938

G 13510
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 Low St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Hutchins (JACKSON)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1885

8. AGE: Years	Months	Days	If less than one day
58	5	20	hr. min

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name Cora
15. Birthplace Md

16 (a) Informant B. C. H. Records
(b) Address [illegible] Eastern Ave.

17 (a) Burial (b) Date thereof 2 - 1 - 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest Cem
Location Towson Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 JAN 31 1944 Waiting for [illegible]
(Registrar's signature) (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 27 1944 at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 1 1943 to 1 27 1944 and that I last saw h[illegible] alive on 1 27 1944.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to HCVD

Due to

Other Conditions Gen. arterio-sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergeant M. D.
Address B C H Date signed 1 30

13511 HEALTH DEPARTMENT—CITY OF BALTIMORE G 13511

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 W. North Ave St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 27 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

If U. S. Veteran specify WAR

2. FULL NAME Walter Wise Rodgers

(a) Residence: No. 1806 West North Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

6a. If married, widowed, or divorced: HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) August 15, 1867

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Carpenter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. C.E. Creasy

10. Date deceased last worked at this occupation (month and year) 1935

11. Total time (years) spent in this occupation 10yrs

12. BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

FATHER

13. NAME John Thorpe Rodgers

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Margaret Almira Mayfield

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Marshall Rodgers

(Address) 1806 W. North Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Olivet-Randall Town Date 1/31/44 19

19. UNDERTAKER Wm. J. Tschenys & Sons

(Address) Baltimore, Md.

20. FILED 1/31/44 19

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) January 30, 1944

22. I HEREBY CERTIFY, That I attended deceased from October 13 1942 to January 30 1944

I last saw him alive on January 10 1944 Death is said to have occurred on the date stated above, at 8:15 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Occlusion	1/30/44
Other contributory causes of importance:	
Coronary Occlusion	10/3/44
Hypertension (Essential) & Arteriosclerosis	1935

Was an operation performed? Yes Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) W. Grafton Harshbarger M. D.

(Address) 214 Medical Arts Bldg

OCCUPATION is very important. See instructions on back of certificate.

VS 3

13512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1 a

Registered No. G 13512

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3712 Greenmount Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Esther Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife JAMES A. JONES
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) SEPT. 2, 1865

8. AGE: Years	Months	Days	If less than one day
78	4	27	hr. min.

9. Birthplace FOREST HILL, HARFORD Co., MD
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name LLOYD R. MARTIN
13. Birthplace HARFORD CO., MD.

MOTHER
14. Maiden Name ELIZABETH A. GRAFTON
15. Birthplace HARFORD CO., MD.

16 (a) Informant Mr. A. Howard Jones
(b) Address 3712 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Centre M.E. Forest Hill Jar
Location Forest Hill, Md.

18 (a) Funeral director W. J. Tracknor & Sons
(b) Address Balto., Md.

19 (a) JAN 31 1944 (Date received by Registrar) (b) Huntington Williams, Jr. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1944, at 7:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1944 to Jan. 29 1944 and that I last saw h e alive on Jan. 27 1944

Immediate cause of death	Duration
Myocarditis (sclerotic)	5 yrs.
Due to Hypertension	10 yrs.
Due to Nephritis (chronic)	Many yrs
Other Conditions Arterio-sclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harley R. Taggart M. D.
Address 3812 Greenmount ave Date signed 1/29/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

G 13513
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Cynda Sykes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Louis C Sykes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20-1880

8. AGE: Years 63 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name ? Taylor
13. Birthplace Baltimore

MOTHER
14. Maiden Name Pauline ?
15. Birthplace Balto

16 (a) Informant Mr Louis C Sykes
(b) Address 1410 N. Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Leonard J Buck
(b) Address 5305 Loyola Blvd.

JAN 31 1944 (Date rec'd by registrar) (b) Huntingtown Calvert Co. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1944, at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1944, to 1-30 1944, and that I last saw h alive on 1-30 1944.

Immediate cause of death Probably pulmonary embolism — Duration

Due to Recent laparotomy

Due to Intra abdominal tumor

Other Conditions over

(Include pregnancy within 3 months of death)

Date of operation 1-22-44

Major findings of operation: Abdominal carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Taylor M. D.
Address Sinai Hospital Date signed 1-31-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

XV G 13514

Registered No. 1192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga 41

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2502 Taylor Ave. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

✓

3 (a) FULL NAME Baby Girl Farrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-15-43 15 days old

8. AGE: Years	Months	Days	If less than one day
0	0	15	hr. min.

9. Birthplace Mercy Hosp. Baltimore, Md. (town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name Thomas J. Farrell

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Margaret Reaser

15. Birthplace ~~Baltimore~~ W. Va.

16 (a) Informant Margaret Farrell

(b) Address 2502 Taylor Ave Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location .....

18 (a) Funeral director Leonard J. Kusch

(b) Address 5305 Harford Rd

19 (a) JAN 21 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1944, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1944, to 1-30 1944, and that I last saw h[illegible] alive on 1-30 1943.

Immediate cause of death Dehydration — Duration

Due to Diarrhea

Due to .....

Other Conditions Premature

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature J. R. Sylvia M. D.

Address Mercy Hosp. Date signed 1-30-44

G 13515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

Registered No. G 13515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Maple Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanne Nemethy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7 1942

8. AGE: Years 1 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Nemethy

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Delores Kostack

15. Birthplace Balto Md Pennsylvania

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Bleff Road

18 (a) Funeral director Thos. L. Elgin

(b) Address Holabird & Elgin

JAN 31 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1944, at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1944 to Jan 28 1944, and that I last saw h[illegible] alive on Jan 28 1944.

Immediate cause of death

Duration

Resp. failure

Due to tuberculous meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Rogers Kaye M.D.

Address [illegible] Date signed

G 13516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13516 Registered No.

1040

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2030 Maisel Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton T. Marsh.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 6-1943

8. AGE: Years	Months	Days	If less than one day
	10	22	hr. — min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Walter E. Marsh.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mildred L. Bowen.
15. Birthplace Baltimore - Md.

16 (a) Informant Mildred L. Marsh.
(b) Address 2030 Maisel St.

17 (a) Burial. (b) Date thereof Jan. 31-44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) JAN 31 1944 Huntington Williams MD
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28- 1944, at 2.35 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Uffer Perforation Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-29-44

13517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

Registered No. G 13517

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. G. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Edward Richardson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White.

6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 26-44

8. AGE: Years | Months | Days 2 | If less than one day hr. — min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Norman L. Richardson.
13. Birthplace Baltimore. Md.

MOTHER
14. Maiden Name Marie Melchior.
15. Birthplace Baltimore. Md.

16 (a) Informant Norman L. Richardson.
(b) Address 1814 W. Franklin St.

17 (a) Burial - (b) Date thereof Jan. 31-44.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) (b) Huntington Williams, M.D.
(Signature and title)

JAN 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 28 1944 at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 26 1944 to 1 28 1944 and that I last saw him alive on 1 28 44 19

Immediate cause of death Status thymolymphaticus

Due to Enlarged thymus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Enlarged thymus

Duration 2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. N. Friedman M. D.

Address W. B. G. H. Date signed 1/29/44

FOR WHITE FRANCIS, WITH UNDERTAKER'S COMPLIMENTS. Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Statistical information is especially important. Please write correct age in years, months, days, hours, minutes.

13518
~~448219~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13518
Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument Sts.
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 19 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME VIVIAN Marie RAYNES

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: ● | Months: 3 | Days | If less than one day: hr min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lloyd RAYNES
13. Birthplace Va.

MOTHER 14. Maiden Name Edith ?
15. Birthplace PA.

16 (a) Informant records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2. 2. 44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A.Co

18 (a) Funeral director Robert L. Brooks
(b) Address 1338 Hollins Street
(c) (Date received by registrar) JAN 31 1944 Huntington Station, Md. Registrar

VS 160

PLEASE WRITE PLAINLY. WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1944 at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1944 to Jan 30 1944 and that I last saw him alive on Jan 30 1944.

Immediate cause of death Bronchopneumonia — Duration 14 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Saunders M. D.
Address 1324 Hollins St Date signed 1/30/44

G 13519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 152

Registered No. 2549

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Hospital~~ Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 408 E. Joppa Road
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Infant J Frances LeCompte

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/23/44

8. AGE: Years	Months	Days	If less than one day
		6	hr. ..... min.

9. Birthplace University Hospital
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name H. Lloyd LeCompte, Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances Miller
15. Birthplace Washington D. C.

16 (a) Informant Mrs. Frances LeCompte
(b) Address 408 E Joppa Road Towson Md.

17 (a) Burial (b) Date thereof Jan 31 44
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor ave

18 (a) Funeral director John A. Moran
(b) Address 3900 E. Baltimore St.

19 (a) JAN 31 1944 (b) ..... Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29 1944, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1944 to 1/29 1944
and that I last saw h[er] alive on 1/27 1944
Immediate cause of death Septicemia — Duration .....
Due to Cellulitis of Back. — Duration .....
Due to ..... — Duration .....
Other Conditions ..... — Duration .....
(Include pregnancy within 3 months of death)
Major findings:
Of operations ..... — Duration .....
Of autopsy ..... — Duration .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Thos. E. D. Kohn M. D.
Address Univ. Hosp. Date signed 1/29/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G 13520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 13520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Linden ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Weber

3 (b) If veteran, name war —

3 (c) ~~Social~~ Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married, widowed,~~ or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5/28/1868

8. AGE: Years 75 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Brew Master

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. M. Woodman
(b) Address 3212 E Balt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Taylor Ave

18 (a) Funeral director John C Morgan
(b) Address 3000 E Balt St

19 (a) Filed 2-1-1944 (b) Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28- 1944, at 11:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 1-29-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 107

G 13521 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES G. PHILIPS ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	7	3	hr. min.

9. Birthplace La Crosse, Wis (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER	12. Name Lonnie James Phillips
	13. Birthplace Johnson City, Tenn.
MOTHER	14. Maiden Name Rosemary Bochart
	15. Birthplace La Crosse Wis.

16 (a) Informant Lonnie Phillips
(b) Address 2128 St Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-40 (month) (day) (year)
(c) Cemetery or crematory St. Charles Church.
Location Pikesville Md.

18 (a) Funeral director Spring Byers
(b) Address 5005 Park Heights Ave

19 (a) JAN 31 1940 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1940, at 10 A M

21. I certify that I took charge of the remains described above, held an inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular
primary

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Willenmeier M.D. Medical Examiner.
Date signed

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓ G 13522

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3701 Greenmount Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 3701 Greenmount Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATE F. RICKETTS

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1856

8. AGE: Years	Months	Days	If less than one day
87	2	2	hr. min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Thomas Roberts

13. Birthplace Edington, N. C.

MOTHER

14. Maiden Name Margaret Sheldon

15. Birthplace Baltimore

16 (a) Informant Mrs. Arthur Ricketts

(b) Address Freeport, L. I.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)

(c) Cemetery or crematory Greenfield Cem.

Location Long Island, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date received (month) (day) (year) JAN 31 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1944, at 6 9. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 17 1944, to January 30 1944, and that I last saw h alive on January 29 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 days
Due to Hypertension	years
Due to Arteriosclerosis Senescence	years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Lee Hansen M. D.

Address 20 E. Preston Street Date signed 1/30/44

G 13523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13523 Registered No. 92c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 E. Madison (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Calvin E. Shannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1917

8. AGE: Years: 26 | Months: 1 | Days: 5 | If less than one day: hr. min

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Levi Shannon
13. Birthplace N. C

MOTHER
14. Maiden Name Millie Spruill
15. Birthplace N. C.

16 (a) Informant Mittie Shannon
(b) Address 1211 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Joseph S. Cook, Jr.
(b) Address 1 East N. Central Ave Huntington Park, Calif.

19 (a) JAN 31 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1944, at 6:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Rheumatic endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner
Date signed January 30, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

13524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82B

G 13524
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item is important and should be correctly supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 W. Lombard St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 19
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 W Lombard St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy M. Stonesifer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife J Milton Stonesifer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 27-1873

8. AGE: Years	Months	Days	If less than one day
70	1	3	hr. — min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Unknown Harris
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Thomas H. Martin
(b) Address 1433 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Geo L. Beyer Jr
(b) Address 1512 Hollins St

JAN 31 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1944, at 12:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1943 to Jan 30 1944, and that I last saw h alive on Jan 30 1944.

Immediate cause of death	Duration
Cerebral thrombosis	3 days
Due to arteriosclerosis	6 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Mortimer Neal M. D.
Address 2196 St Paul Date signed 1/31/44

G 13525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G 13525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 Pitcher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Pitcher St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Rebecca Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female 5. Color or race Colored 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John T

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1868

8. AGE: Years 75 Months 1 Days 4 If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ? Edmonds
13. Birthplace Md

MOTHER 14. Maiden Name Louisa Shaw
15. Birthplace Md

16 (a) Informant John T. Smith
(b) Address 620 Pitcher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-44 (month) (day) (year)

(c) Cemetery or crematory Western Star
Location Balto Co. Md.

18 (a) Funeral director Mrs. Geo. F. Holland
(b) Address 163 Druid Hill Ave.

JAN 31 1944 Huntington Phillips, M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29-1944 at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1943 to 1/29 1944.
and that I last saw h[illegible] alive on 1/29 1944.

Immediate cause of death Carcinomatosis
Metastasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 5 Mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Jansen M. D.
Address Coon Chicken Date signed 1/31/44

C 13526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C 13526

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1437 W. Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Williams

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife George F
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-1866

8. AGE: Years 77 | Months 10 | Days 17 | If less than one day: hr. min.

9. Birthplace Winston N. C.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. George Williams
(b) Address 1437 W. Lanvale St.

17 (a) Burial (b) Date thereof 1-31-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid M. Park
Location Balto Co. Md

18 (a) Funeral director Mrs. Geo. A. Holland
(b) Address 1631 Druid Hill Ave.

JAN 31 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to Jan 27 1944 and that I last saw h alive on Jan 27 1944

Immediate cause of death: Myocarditis — Duration: 2 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts
Address 515 Lexington Date signed 1/31/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

13527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 13527
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2066 Kennedyare
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3/1

(e) Length of stay in Baltimore (yrs., mos., or days) 43

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1513 Bank St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angelina Vendetti

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22 1879

8. AGE: Years 64 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Marshal Reviglia
13. Birthplace Italy

MOTHER
14. Maiden Name Vennaranna Materazz
15. Birthplace Italy

16 (a) Informant Mary Vitale
(b) Address 2066 Kennedyare.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/44 (month) (day) (year)

(c) Cemetery or crematory H. Rosedale
Location Belair Rd.

18 (a) Funeral director M. W. E. Daniels Sons
(b) Address 4 & A Sts Williamsport, Md.

JAN 31 1944 Huntingtown
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1944 at 11:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1944 to Jan 29 1944 and that I last saw her alive on Jan 29 1944

Immediate cause of death: Acute Cerebral Hemorrhage — Duration

Due to Chasteris Sclerosis

Due to Ch Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. G. Hornstein M. D.

Address 733 Anquith St Date signed 1/31/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly

C 13528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. C 13528

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2422 E. Madison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Winkler

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Charles Winkler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/10/93

8. AGE: Years 50 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation housewife.
11. Industry or business home

FATHER 12. Name John Appitz
13. Birthplace Austria

MOTHER 14. Maiden Name Mary Steindl
15. Birthplace Austria

16 (a) Informant husband
(b) Address 2422 E. Madison St

17 (a) Burial (b) Date thereof 2/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles E. Schuppinal
(b) Address 2601 E. Madison, Street

19 (a) Date received JAN 21 1944 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1944 at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1943 to Jan 30 1944
and that I last saw h[illegible] alive on Jan 25 1944

Immediate cause of death: Coronary Thrombosis — Duration 1/60/44
Due to Chr. Myocarditis — 7/1/43
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Roamer M.D.
Address 801 Eastern Ave Date signed 1/31/44

G 13529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G 13529 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 Ashland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Ashland Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Tromer

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 215-10-7338

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary (nee Benes)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/89

8. AGE: Years	Months	Days	If less than one day
55 yrs.	-	4	hr. min.

9. Birthplace Kansas (Town, county, and state)
10. Usual Occupation
11. Industry or business Crown, Cork & Seal

FATHER
12. Name John Tromer
13. Birthplace Austria

MOTHER
14. Maiden Name Frank
15. Birthplace Austria

16 (a) Informant Dolores Beran (daughter)
(b) Address 2513 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) JAN 31 1944 (Date rec'd by registrar) (b) Huntington Hillcrest, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1944 at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1943 to Jan. 28 1944 and that I last saw him alive on Jan. 27 1944

Immediate cause of death: Chronic Valvular Heart Disease — Duration: ?

Due to

Due to Rheumatic Fever when a boy.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Vincent H. Dooka M.D.
Address 845 N. 22d St. Date signed 1/30/44

C 13530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927

Registered No. C 13530

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1639 Westwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 Westwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME J. Robert Soden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Sadie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1893

8. AGE: Years	Months	Days	If less than one day
50	7	25	hr min

9. Birthplace Md Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business P. O.

FATHER
12. Name Thomas H Soden
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie Fountain
15. Birthplace Md.

16 (a) Informant Sadie Soden
(b) Address 1639 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director Mrs Robt A. Elliott & Dgt
(b) Address 129 N. Carrollton

19 JAN 31 1944 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27- 1944 at 10-0 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10- 1943 to 1-27- 1944 and that I last saw h in alive on 1-27- 1944

Immediate cause of death Chronic Valvular Heart Disease — Duration 3 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George C Page M. D.
Address 1816 N. Monroe St (17) Date signed 1-30-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13531

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 107

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jockey Sharper

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-3486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	married

6 (b) Name of husband or wife Mabel

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 1-9-09

8. AGE: Years	Months	Days	If less than one day
35 34	-	21	hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jockey Sharper
13. Birthplace S.C.

MOTHER
14. Maiden Name Betty Grove
15. Birthplace S.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 2, 1944 (month) (day) (year)

(c) Cemetery or crematory
Location Florence S. Carolina

18 (a) Funeral director Mrs. Robert A. Elliott & Dgt.
(b) Address 1129 N Carolina Street

19 (a) JAN 31 1944 (Date rec'd by registrar) (b) Washington Pollinger M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1944 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1944 to 1/30 1944 and that I last saw him alive on 1/29 1944.

Immediate cause of death Bronchopneumonia

Due to lung abscess

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 1/14/44

Major findings of operation: Large

of autopsy:

Duration
6 wk.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Saunders M.D.
Address Johns Hopkins Date signed 1/30/44

G 13532
JL- 86176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13532
Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: altimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Berzelius Peterson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Hazel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1896

8. AGE: Years	Months	Days	If less than one day
47	10	16	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Peterson
13. Birthplace Va.

MOTHER
14. Maiden Name Amy Jackson
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31-1944 (month) (day) (year)
(c) Cemetery or crematory Petersburg Va.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 922 N. Schroeder St.

19 (a) (Date received by registrar) (b) Huntington Williams, Md.

JAN 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1944. at 155 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1944. to 1-28 1944., and that I last saw him alive on 1-28 1944.

Immediate cause of death Uraemia — Duration 2

Due to Nephrosclerosis — Duration 2

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes, Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H. Titus M. D.
Address [illegible] Date signed 1-31-44

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 13533
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 N. Pobbleton
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N. Pobbleton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida V. King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fmale
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24-1886

8. AGE: Years 57 | Months 3 | Days 5 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: House wife
11. Industry or business

FATHER
12. Name: Isaac Worsham
13. Birthplace: Va

MOTHER
14. Maiden Name: Amanda Jamison
15. Birthplace: Baltimore

16 (a) Informant: Joseph King
(b) Address: 111 N. Pobbleton

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof: Feb 2-44
(day) (year)
(c) Cemetery or crematory: Mt. Auburn Cem
Location

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N. Edwards

19 (a) JAN 31 1944
(Date rec'd by registrar)
(b)
Registrar

VS 150

Thurlington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29 1944 at 830 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1943 to Jan 29 1943 and that I last saw h alive on Jan 28 1943

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature: F. E. Kank M. D.
Address 1 North Rutt Pobble signed Jan 30

correct age is especially important. Physicians: please write the cause of death clearly

G 13534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

Registered No. G 13534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
General German Aged People's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. Lert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	widow

6 (b) Name of husband or wife late Ferdinand C. Ehut

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2nd 1869

8. AGE: Years	Months	Days	If less than one day
74	4	26	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christopher Schutz
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Frantzlen
15. Birthplace Balto. Md.

16 (a) Informant German Aged Home
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Mount Hedge
Location Lutherville Md

18 (a) Funeral director Harry A. Fiske
(b) Address 401 E. Monument Ave.

19 (a) (b) Huntington Williams, Md

JAN 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1944, at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5/44 to Jan. 28/44, and that I last saw her alive on Jan. 25/44.

Immediate cause of death	Duration
Chronic Cardiac Dilitation	Unkno wn.
Due to	
Due to	
Other Conditions Acute Influenza.	7 days.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Ward Elmer M. D.
Address 933 Hamburg Date signed Jan 29/44

13535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G 13535
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Elgin Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Elgin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise C. Du Brau

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Otto M Du Brau

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1863

8. AGE: Years: 78 | Months: 1 | Days: 17 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leopold Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Steinmetz
15. Birthplace Germany

16 (a) Informant Otto M Du Brau
(b) Address 3205 Elgin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Harry A. Wiltse
(b) Address 410 E Lmondson Ave.

19 Received [illegible] Huntington Williams, M.D. Registrar

JAN 31 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28/ 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from sometime Oct. 1940, to January 1944, and that I last saw her alive on Dec. 16th 1943.

Immediate cause of death
Embolic — Duration: Five years.

Due to Arteriosclerosis of the brain and the heart Renals

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred L. Ledermann M. D.
Address 3E. Preston Str. Date signed Jan 29. 44

G 13536

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 13536
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 E Clement St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 E Clement St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie T Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F. M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Sept 30 1863

8. AGE: Years	Months	Days	If less than one day
80	3	28	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Philip Myers
13. Birthplace Md

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Md

16 (a) Informant Miss Pearl Morgan
(b) Address 520 E Clement St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md

18 (a) Funeral director William M Mareck
(b) Address 746 Light St

JAN 31 1944
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1944, at 3 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1942 to Jan 28 1944
and that I last saw h[illegible] alive on Jan 28, 1944.

Immediate cause of death — Duration

Arteriosclerotic Heart Disease

Due to

Due to

Other Conditions Cardiac Dilatation Senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent M Mancini M. D.
Address 1403 S. Charles St Date signed 1/8/44

G 13537

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G 13537

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 E Hoffman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) q
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 E Hoffman St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fredrick W. Ihle

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E Ihle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30th 1897

8. AGE: Years	Months	Days	If less than one day
46	6	29	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Gas & Electric Co

FATHER
12. Name Jacob F Ihle
13. Birthplace Germany.

MOTHER
14. Maiden Name Augusta Stammann
15. Birthplace Germany

16 (a) Informant Mrs Mary Ihle
(b) Address 2027 E Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1st 1944 (month) (day) (year)
(c) Cemetery or crematory Balto. Mem
Location E North Ave Ext

18 (a) Funeral director Leo G. Lovgk.
(b) Address 1701-03 N Patt Park Ave

19 (a) 1/31/44 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29th 1944 at 6.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1943 to Jan 29 1944.
and that I last saw h[illegible] alive on Jan 10 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas B Marsh M.D.
Address 501 Johnson Date signed 1/30/44

PLEASE WRITE PLAINLY with pen or indelible pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

13538
#8096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

Registered No. C 13538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Annes
(c) City or town Chester (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day: hr min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER
12. Name Charles Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Georgeana
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-44 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Chester Md.

18 (a) Funeral director Lowry & Henry
(b) Address Cambridge Md.

19 (a) JAN 31 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1944 at 2:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1944 to Jan. 30 1944 and that I last saw him alive on Jan. 30 1944

Immediate cause of death: Cardiac failure — Duration 10 days

Due to

Due to arteriosclerotic heart disease with auricular fibrillation — 10 days

Other Conditions Pulmonary tuberculosis Hemiplegia due to cerebral hemorrhage

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Graham Councilman

Address S. Hopkins Date signed 1-30-44

VS 150

13539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13539

Registered No. 182a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 Wilcox Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Wilcox Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH WILHELM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min

9. Birthplace Baltimore Maryland (Town, County and State)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Wilhelm
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JAN 21 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 JAN 31 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1944, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation in bed clothes accident.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-19-44 at 6 A. 10/1 M.
(b) Where did injury occur? 1206 Wilcox Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocated by bedclothes.

23. Signature H. L. Williams M.D.
Medical Examiner.
Date signed 1-20-44

0690

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 13540

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Henry Pearson

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 1899

8. AGE: Years 45 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace .....
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory .....
Location JOHNS HOPKINS MEDICAL SCHOOL JAN 31 1944

18 (a) Funeral director Commissioner of Health
(b) Address .....

19 JAN 31 1944 Wesley Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1943, at 11:10 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary occlusion
arteriosclerosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... A.M. P.M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury .....

23. Signature W. L. Wellemeyer M.D.
Medical Examiner.

Date signed 1-31-44

VS 151

0691

G 13541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

G 13541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 Carlton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hinch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JAN 31 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 31 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 19 44 at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular-renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Grayson M.D.
Medical Examiner
Date signed Jan 9 1944

0692

G 13542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170

G 13542 Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution: Sinai Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1225 Hammonds Lane (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Janet Dale BOLES

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 12. 1942

8. AGE: Years	Months	Days	If less than one day
1	2	18	hr. min.

9. Birthplace Lynchburg Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Thomas R Boles

13. Birthplace Va.

MOTHER

14. Maiden Name Emma Grohoon

15. Birthplace Va.

16 (a) Informant Emma Boles

(b) Address 1225 Hammonds Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)

(c) Cemetery or crematory Lynchburg

Location Lynchburg Va

18 (a) Funeral director Wilson & Dorsey

(b) Address 1217 Light St

19 (a) JAN 31 1944 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30, 19 44, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 19 44, to Jan 30 19 44, and that I last saw her alive on Jan 30 19 44.

Immediate cause of death Tetanus — Duration

Due to Cirrhosis

Due to Malnutrition

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles B. Macdonald M. D.

Address 1213 Light St Date signed Jan 30 44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

G 13543 G 13543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4321 Marshall Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country
Marble Hall

3 (a) FULL NAME Mrs Irene Bartoner

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Norman H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1878

8. AGE: Years	Months	Days	If less than one day hr.	min.
65	7	13		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Wilbur Smith
13. Birthplace Ft Mary Co Md

MOTHER
14. Maiden Name Isabella Hall
15. Birthplace Fort Moylond Co Pa

16 (a) Informant Leland L Bortner
(b) Address 4410 Richfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Catonsville Md

18 (a) Funeral director Wilbur Smith & Son
(b) Address 1217 E Fayette St

19 (a) Thurlington Williams, M.D. Registrar
(b) JAN 31 1944 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1944, at 9:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1944, to Jan 30 1944, and that I last saw her alive on Jan. 30 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchial pneumonia	4 da.
Due to Cardiac Failure — Rheumatic Carditis	1 yr. 30 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maryland Edward Bay M. D.
Address Women's Hospital Date signed

VS 8

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13544

AB-85970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 13544

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1538 Boyle St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Herzberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10-1889

8. AGE: Years	Months	Days	If less than one day
54	7	8 19	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Balt City Fork Boom Co

FATHER

12. Name George Herzberger (D)

13. Birthplace Md.

MOTHER

14. Maiden Name Kate Snyder

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address RECORDS

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Location Baltimore Md

18 (a) Funeral director Wilhoyte Funeral Home Inc

(b) Address 1219 E. Coul St

19. (a) 1944 (Registered by registrar) (b) Washington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29 1944 at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1944 to 1/29 1944 and that I last saw him alive on 1/29 1944.

Immediate cause of death: Pulmonary TBC — Duration: 3 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Seigman M.D.

Address BCH Date signed 1/30

G 13545

G 13545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution McKenna Clinic No
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Battolety
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1941 W. Balto. St
(If rural give location)
(e) Citizen of foreign country? - No - (Yes or No)
If yes, name country -

3 (a) FULL NAME Katharine Pletzing

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Nov. 24-1862
8. AGE: Years 81 | Months 2 | Days 6 | If less than one day: hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Philip Pletzing
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Koehler
15. Birthplace Germany

16 (a) Informant Mrs H.F. Tennyson (neice)
(b) Address 1941 W. Balto St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.
18 (a) Funeral director Jos. Saunders Sons,
(b) Address 192 Park Ave.
(c) JAN 31 1944 (Date received by registrar) (Signature for Williams U.P. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1944 at 3 A. M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1944 to Jan 30 1944 and that I last saw her alive on Jan. 30 1944.

Immediate cause of death: Cardio-vascular hypertension disease — Duration: 4 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Norman L. Todd M. D.
Address 735 N. Fulton Ave Date signed 1/31/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 180

G 13546 G 13546G

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 - 7 - 24
(e) Length of stay in Baltimore (yrs., mos., or days) 21 - 7 - 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County
(c) City or town New Britain (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Stanley Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rev. Edward M. Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1875

8. AGE: Years	Months	Days	If less than one day
69	—	26	hr. min.

9. Birthplace New Britain, Conn. (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER 12. Name John Hayes
13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth Maloney
15. Birthplace New Britain, Connecticut

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-44 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location New Britain Conn.

18 (a) Funeral director Sherwood Myers Co.
(b) Address 1040 North Ave.

19 (a) JAN 31 1944 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1944, at 2:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1934, to Jan 31 1944, and that I last saw him alive on Jan. 31 1944.

Immediate cause of death	Duration
Arteriosclerosis	8 days
Due to Arteriosclerosis	22 yrs.
Due to	
Other Conditions Paranoid syndrome	22 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address Date signed

VS 3

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C-135477093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 S. Fremont St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Bl | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas W.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Balto., Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS HOSPITAL ... JAN ... 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 1944 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1944 at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1944, to Jan. 26 1944, and that I last saw h[illegible] alive on Jan. 26 1944.

Immediate cause of death: Uremia — Duration
Due to: Premature birth
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. N. Ingram, M.D.
Address Univ. Hosp. Date signed 1-27-44

VS 180

0695

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13548

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13548 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 W Fayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph C. Waldsachs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Bessie Hughes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 9, 1890

8. AGE: Years 54 | Months | Days 20 | If less than one day hr. min.

9. Birthplace: Balto. Co. (Town, county, and state)

10. Usual Occupation: Police

11. Industry or business: Balto Police Dept.

FATHER
12. Name: Stephen Waldsachs
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mrs. Bessie Waldsachs
(b) Address: 2023 W. Fayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Moriah
Location: Towson, Md.

18 (a) Funeral director: Martin Harper & Sons
(b) Address: 1827 W. Baltimore St. Phillips, Md.

19 (a) Filed JAN 2 1944 (b) (Registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1944, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 16/2

(a) Date of injury January 29, 1944 M.
(b) Where did injury occur? 1432 W. Lafayette Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? Yes
(d) Means of injury Fell down stairs

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed January 30, 1944

~~4417~~ ~~G~~ 13549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 13549 Registered No. 74a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ANNE ARUNDEL
(c) City or town ANNAPOLIS (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 MAIN ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gialetis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 14, 1887 ~~9-14-85~~

8. AGE: Years	Months	Days	If less than one day
56 ~~57~~	4	15	hr min

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Watchmaker
11. Industry or business Self

FATHER
12. Name Nicholas Mick Gialetis
13. Birthplace Greece

MOTHER
14. Maiden Name Helen Gevebnas
15. Birthplace Greece

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18 (a) Funeral director E. W. Bannerman
(b) Address 1003 W. Baltimore St.

19 (a) Feb 1 1944 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1944 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Dec 25~~ 1943 to Jan 29 1944 and that I last saw h~~im~~ alive on Jan 29 1944.

Immediate cause of death — Duration

B hem strep pharyngitis

Due to Septicemia

Due to chronic lymphocytic leukemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R Birmingham M.D.
Address JHH Date signed 1-31

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 13550 G 13550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. .....

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2026 Orleans St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Klein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	8	27		

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Bar tender

FATHER
12. Name Samuel Klein
13. Birthplace Balto md.

MOTHER
14. Maiden Name Sarah Stern
15. Birthplace Balto md.

16 (a) Informant Sol Klein
(b) Address 2608 Violet ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Shelaw Friendship
Location E. Balto St
18 (a) Funeral director Bol Jennison Bro
(b) Address 1124 W North ave
19 (a) 2-1-1944 (Date rec'd by registrar) (b) Registrar's signature for William Maguire

JAN 31 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1944 at 4 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1943 to Jan 22 1944 and that I last saw him alive on Jan 22 1944.

Immediate cause of death	Duration
Cardiac failure	2 mins
Due to Cardio Vascular disease	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. J. Sankin M. D.
Address 20 N. Milton Ave Date signed 1/31/44

G 13551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13551

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution: Monument & Rutland Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 0

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3616 Glen Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Middleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9. 1883

8. AGE: Years	Months	Days	If less than one day
60	11	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Merchant

FATHER

12. Name Pincus Middleman

13. Birthplace Russia

MOTHER

14. Maiden Name Brinai Pekofsky

15. Birthplace Russia

16 (a) Informant Paul Middleman

(b) Address 3316 Dorchester Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/44 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cemetery

Location Sandown

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Burington or Williamsport

JAN 31 1944

8

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30/44 19 at 1:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 1/30/ 1944

Immediate cause of death Cardiac failure — Duration

Due to acute myocardial infarction

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Aikman M. D.

Address Sinai Hosp. Date signed 1/30/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13552 / 107

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 STROMEYER WAY
(c) Hospital or institution:

26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or day) 4 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 STROMEYER WAY
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLYDE WOODROW MAYS

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUG. 26 1942

8. AGE: Years	Months	Days	If less than one day
1	5	5	hr. ..... min.

9. Birthplace NORTH CAROLINA
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name REECE T. MAYS
13. Birthplace N.C.

MOTHER
14. Maiden Name ELSIE MATHIAS
15. Birthplace N.C.

16 (a) Informant REECE T. MAYS (FATHER)
(b) Address 1311 STROMEYER WAY

17 (a) BURIAL (b) Date thereof 2/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory PLEASANT GROVE
Location Wilkes County N.C.

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) JAN 31 1944 (b) [illegible] Williams, M.D. Registrar
Huntington

VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JAN. 31 1944 at 10/30

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 19 . to Jan 31 1944
and that I last saw him alive on Jan 30 19 44

Immediate cause of death: Bronco Pneumonia — Duration .....
Due to Premature Birth .....
Due to Has died has been sick since birth .....
Other Conditions Brain Condition .....
(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation: no
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) — (County) — (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adam A Ford M. D.
Address 1126 Druid Park Dr. Date signed Jan 31 44

JAN 31 1944

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13553 Registered No. 107

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Oakford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Chloe D. Kalar

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	wh	married

6 (b) Name of husband or wife Sylvia D. Kalar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1886

8. AGE: Years	Months	Days	If less than one day hr.	min.
57	2	25		

9. Birthplace Mount Montrose (Town, county, and state) W. Va
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Stout
13. Birthplace W. Va.

MOTHER
14. Maiden Name Harriet Shumaker
15. Birthplace W. Va.

16 (a) Informant Sylvia D. Kalar
(b) Address 3004 Oakford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Fredes
Location Carroll Co Md

18 (a) Funeral director C. Howard Evans
(b) Address 1405 Edmondson Ave

JAN 31 1944 (Date rec'd by Registrar) (b) Arlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1944 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1944 to 1/30 1944 and that I last saw h[illegible] alive on 1/30 1944.

Immediate cause of death	Duration
Myocardial failure	
Due to Bronchopneumonia	
Due to	
Other Conditions Pos tuberculosis Cerebral hemorrhage (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Aikman M. D.
Address Sinai Hosp Date signed 1/31/44

G 13554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G 13554 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland St Joseph's Hos.

(b) Street address 1400 N. Caroline Atreet

(c) Hospital or institution: St Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State D. C. (b) County

(c) City or town Washington (If outside city or town limits, write RURAL and give town)

(d) Street No. 705 Otis Place N. W. (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME SCALCO? Mrs Dorthea

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Maried

6 (b) Name of husband or wife Salvatore Scalco

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1897

8. AGE: Years	Months	Days	If less than one day: hr	min.
46	2	10		

9. Birthplace Sicily, Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Nicola Inaprera

13. Birthplace Italy

MOTHER 14. Maiden Name Theresa Culotta

15. Birthplace Italy

16 (a) Informant Mrs. Mary D. Patti

(b) Address 2839 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2-1944 (month) (day) (year)

(c) Cemetery or crematory St. Mary's Catholic Cem. Location 2121 Lincoln Road, N.E. Wash D.C.

18 (a) Funeral director Joseph Fanaro Inc.

(b) Address 2013 Rhenmount Place Huntington Williams, Mgr.

JAN 31 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1944 at 5.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1944 to 1-30 1944, and that I last saw her alive on 1-30 1944.

Immediate cause of death	Duration
Lobar Pneumonia (circulatory failure)	
Due to	
Due to	
Other Conditions: Cancer of sigmoid (Include pregnancy within 3 months of death)	

Date of operation 1-27-44

Major findings of operation: Ca. of sigmoid

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Nathan P. Colodny M. D.

Address St Josephs Hosp. Date signed 1-30-44

Please write plainly, with ink. Use no abbreviations. Omit no items. Use the accompanying supplies. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G 13555 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 N. Washington Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Washington Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Segall

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Harry Segall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Leopold Klein
13. Birthplace Hungary

MOTHER
14. Maiden Name Rose
15. Birthplace Hungary

16 (a) Informant Harry Segall (Husband)
(b) Address 5 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-44 (month) (day) (year)
(c) Cemetery or crematory Shaarei Tfiloh Friendship
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31- 1944, at 1 P.M. KJ

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating Gas
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-31-44 at 1 A.M.
(b) Where did injury occur? 5 N. Washington St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas range, burner on & unlit.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-31-44

VS 151

13556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13556
Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Sharp St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 S Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ward Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1875
8. AGE: Years 69 | Months | Days | If less than one day: hr. min.
9. Birthplace Balto (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Bishop
13. Birthplace md

MOTHER
14. Maiden Name Priscilla —
15. Birthplace md

16 (a) Informant Lillian E. Jones
(b) Address 2335 Ivy Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location
18 (a) Funeral director James A Davis
(b) Address 142 Wolfe St
19 (a) FEB 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1944 at 10.00 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jan 28 1944, and that I last saw h— alive on Jan 28 1944.

Immediate cause of death: Cerebral Vascular Renal disease — Duration: Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address [illegible] Date signed [illegible] M. D.

WOODLAND

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

13557

XA-86191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13557

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005½ Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Jacobs or Frances Manokey Jacobs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 39 Months ? Days ? If less than one day hr. min. ?

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 FEB 1 - 1944 Signature of local registrar Augustus Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1944, at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1944 to 1/27 1944, and that I last saw h[illegible] alive on 1/27 1944.

Immediate cause of death: Pulmonary edema due to Hypertensive cardio vascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible] none

Duration: 2 / ? / ? / ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mc[illegible] M. D.

Address [illegible] Date signed 1/28/44

Please write in ink. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

Dr. Hess - 876 Park, Blvd. ✓

G 13558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 E

Registered No. G 13558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 S. Carey St.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 S. Carey St. (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Stuart

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife David H. Stuart
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) April 13 - 1868

8. AGE: Years	Months	Days	If less than one day
75	9	17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Home ✓
11. Industry or business ✓

FATHER
12. Name Henry Wolf
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Schmidt
15. Birthplace Germany

16 (a) Informant Mrs. David Stuart Sr
(b) Address Ferndale Md - Balto. 25

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) | 2 (day) | 44 (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Balto. Md.

18 (a) Funeral director Wm. Peter & Son
(b) Address 2503 Edmondson Ave. Hunting on Williams, Inc.

19 (a) 1 - 1944 (Date rec'd by Registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30th 1944, at 1.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to Jan 30, 1944.
and that I last saw him alive on Jan 30, 1944.

Immediate cause of death: Acute Heart Failure — Duration
Due to Myocarditis
Due to Coronary Sclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Louis J. Hess M. D.
Address 876 Linwood Ave Date signed 1/31/44

correct age is especially important. Physicians: please write the cause of death in plain words.

G 13559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. G 13559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor E.Lee,

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Andrew A.Lee,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 29 1860

8. AGE: Years 83 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Andrew Reamy.

13. Birthplace Richmond Va.

MOTHER 14. Maiden Name Catherine Broudus,

15. Birthplace Richmond Va,

16 (a) Informant Miss Catherine E.Lee,

(b) Address 1100 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.2.1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director Robert S.Little,

(b) Address 2700 Edmondson Ave

19 (a) Date received by registrar FEB 1 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 30 1944 at 5.15a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1939 to Jan 30 1944 and that I last saw her alive on Jan 30 1944

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions Arteriosclerosis

Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Richmond, Va.

Address 117 W. 25th St. Date signed Feb 2 1944

correct age is especially important. Physicians: please write the

VS 8

13560 T.N 66376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

C 13560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Silverson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1874

8. AGE: Years	Months	Days	If less than one day
69	9	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business

FATHER
12. Name Frederick Silverson
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta ?
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) Feb 1 1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1944, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1944 to 1/31 1944, and that I last saw him alive on 1/31 1944.

Immediate cause of death

Undetermined

Due to Acut coronary occlusion or pul. embolism ?

Due to

Other Conditions A-S. C.V.D.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman M. D.

Address BCH Date signed 1/31

13561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G 13561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 N Luzerne Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 N Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James M Leston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie C Leston
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) May 22 1872

8. AGE: Years	Months	Days	If less than one day
71	10	8	hr. min.

9. Birthplace Tennessee (Town, county, and state)
10. Usual Occupation Street Cleaning
11. Industry or business Balto City

FATHER
12. Name Edward Leston
13. Birthplace Penn

MOTHER
14. Maiden Name Martha Thorington
15. Birthplace Penn

16 (a) Informant Mrs Annie C Leston
(b) Address 503 N Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 Feb 1 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1944, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1943, to Jan 27th 1944 and that I last saw h[illegible] alive on Jan 27th 1944.

Immediate cause of death Cardiac Failure

Due to Cardio Vascular Disease

Duration: 3 days

Due to

Other Conditions

Include pregnancy within 3 months of death

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J J Faulkner M. D.
Address 100 N Eutaw Date signed 2/1/44

13562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13562 Registered No. 82a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 237 E Lafayette Ave
(c) Hospital or institution —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 237 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Simmons

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
52 51	—	—	hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation
11. Industry or business Home mkr

FATHER
12. Name John M Smith
13. Birthplace England

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant M Simmons
(b) Address 237 E Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 2 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem.
Location

18 (a) Funeral director Mary M Woodfield
(b) Address 501 E 22nd St

19 (a) 1-1-1946 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 1944 at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1943, to Jan 31st 1944, and that I last saw him alive on Jan 30 1944.

Immediate cause of death
Cerebral Hemorrhage — Duration 1 day
Due to Tuberculosis — 1 year
Due to
Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation?
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Jos. A. Chatard M. D.
Address 700 N Cond St Date signed Jan 31 1944

13563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13563 Registered No.

T.N 86222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Andrew St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country U.S.A.

3 (a) FULL NAME Steven Krein

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1875 ?

8. AGE: Years	Months	Days	If less than one day
68	1	6	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Francis Krein
13. Birthplace Maryland

MOTHER
14. Maiden Name Anet Huber
15. Birthplace Balto Md

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 2 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location —

18 (a) Funeral director Mary M. Waldfeld
(b) Address 201 E. Fayette St.

19 (a) 2/11/44 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1944, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/28 1944 to 1/30 1944. and that I last saw him alive on 1/30 1944.

Immediate cause of death Cardiac Failure; Anuresis - Pneumonia — Duration 1 wk (a)

Due to A. S. C.V.D.

Due to

Other Conditions Hem. arteriosclerosis; senility (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. L. Seigman

Address BCH Date signed 1/30 M. D.

13564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Virginia ave. (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Grace D. Taylor

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Richie W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1878

8. AGE: Years 65 | Months 2 | Days 11 | If less than one day: hr min

9. Birthplace: Balto., Md. (Town, county and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Harry Wilson
13. Birthplace: Md.

MOTHER
14. Maiden Name —
15. Birthplace: Unknown

16 (a) Informant: Mr. Richie W. Taylor
(b) Address: 3101 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory: London Pk.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. Tuckers & Sons
(b) Address: Balto., Md.

19 (a) 2/1/44 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 31 1944 at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1944 to 1-31 1944, and that I last saw h alive on 1-31 1944

Immediate cause of death: Meningitis probably Meningococcic — Duration: 7 days
Due to
Due to
Other Conditions: Diabetes Mellitus (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: David Jenam
Address: 11 E. Chase St. Date signed 1/31/44

TENNER

13565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G 13565
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 W. Garrison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MRS. ~~Joseph~~ RENA S. PERI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	WHITE	MARRIED

6 (b) Name of husband or wife Mr. Joseph L Peri
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1905

8. AGE: Years	Months	Days	If less than one day
38	1	25	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Mr. Peter Peri
13. Birthplace Italy

MOTHER 14. Maiden Name Antoinette Calata
15. Birthplace Italy

16 (a) Informant History Sheet
(b) Address

17 (a) Burial (b) Date thereof 2/2/44 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Holy Redeemer ~~Cath. Mutual Ass'n~~
Location Balto, Md.

18 (a) Funeral director Wm. J. Tiefenes & Sons
(b) Address Balto, Md.

19 (a) 2/1/44 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1944, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1944 to Jan 30 1944 and that I last saw her alive on Jan 30 1944

Immediate cause of death Metastatic CARCINOMA — Duration

Due to CARCINOMA of CERVIX

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Vincent Lill M. D.
Address Union Memorial Hosp Date signed 1-31-44

3566

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 13566

CERTIFICATE OF DEATH

93E

1. PLACE OF DEATH

CITY OF BALTIMORE (No. [illegible] St., [illegible] Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Howard S Stephens

If U. S. Veteran specify WAR .....

(a) Residence: No. 235 Maisel St., W. Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed or divorced, HUSBAND of (or) WIFE of: Ida V Stephens 9/13/87

6. DATE OF BIRTH (month, day, year): 1-29-XX

7. AGE: Years: 62 | Months: 4 | Days: 16 | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Machinist

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Car Barn

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Md

FATHER

13. NAME: John Stephens

14. BIRTHPLACE (city or town) (State or country): Md

MOTHER

15. MAIDEN NAME: Emaline Bates

16. BIRTHPLACE (city or town) (State or country): Md

17. INFORMANT: Howard Stephens

(Address) 407 Scott

18. BURIAL, CREMATION, OR REMOVAL

Place: London Pk. Date: 1/3/44 19

19. UNDERTAKER: Wm. J. Tichenor & Sons

(Address) Balto. Md.

20. FILED: 1/4/44 19 ... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): 1-29-XX

22. I HEREBY CERTIFY, That I attended deceased from Dec 1 19 30 to Jany 29 XX

I last saw him alive on 1-25 19 XX Death is said to have occurred on the date stated above, at 7:15 a.m.

The principal cause of death and related causes of importance are as follows:

Myocarditis — Date of onset: 1yr

Other contributory causes of importance:

Sepsis — Date of onset: Today

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) Thos. L. Dean M. D.

(Address) 1 E Mount Vernon Pl

OCCUPATION is very important. See instructions on back of certificate.

VS 8

13567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

G 13567

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton St.
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Aiken St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. VITT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Gustav A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1863

8. AGE: Years	Months	Days	If less than one day
80	5	4	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. Brandt
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Ernst
15. Birthplace Germany

16 (a) Informant Mr. Geo. Wm. Roth
(b) Address 2213 Aiken St.

17 (a) Burial (b) Date thereof 2/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 2 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1944, at 3:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1943, to Jan 31 1944, and that I last saw her alive on Jan 30 1944.

Immediate cause of death	Duration
Bronchio Pneumonia	8 d.
Due to Mitral Regurgitation Recurrent	1 mo
Due to Chr Interstitial Nephritis	1 yr
Other Conditions Arterio Sclerosis Hypertension	1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isa Stevens M. D.

Address 2878 Hartford Rd Date signed 2-1-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13568
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1162 Hanover Pl
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1162 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ida Mae Sullivan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	married

6 (b) Name of husband or wife Raymond R. Sullivan
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 1, 1889

8. AGE: Years	Months	Days	If less than one day
54	8	19	hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Home Duties
11. Industry or business —

MOTHER / FATHER
12. Name George Mandell
13. Birthplace Baltimore
14. Maiden Name Ida Mc. ?
15. Birthplace Baltimore

16 (a) Informant Raymond R. Sullivan
(b) Address 1162 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Frederick & Cole
(b) Address 2008 W Lombard St

FEB 1 - 1944 (Date rec'd by registrar) Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1944, to Jan 29 1944, and that I last saw h[illegible] alive on Jan 24 1944.

Immediate cause of death: Acute Pulmonary Edema — Duration: 2½ hours

Due to Hypertensive Cardio-Vascular disease — 7yrs. ?

Due to —

Other Conditions Diabetes Mellitus — 3yrs ?

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Earl Bass, M.D.
Address 4001 Wilkens Ave Date signed 1-29-44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 13569
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Wylie Ave.
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Baby Girl D'Anthony (ANN MARIE D'ANTHONY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1944

8. AGE: Years | Months | Days | If less than one day
14 days. hr min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Francis D'Anthony
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances D'Anthony
15. Birthplace Baltimore Md.

16 (a) Informant Mercy Hospital
(b) Address

17 (a) Burial (b) Date thereof 2-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director L. Vernard Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1944 at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1944 to Jan 30 1944 and that I last saw her alive on Jan 30 1944.

Immediate cause of death
(a) Asphyxiation

Due to
(b) Pneumonia

Due to
(c)

Other Conditions
Premature

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. R. Inglis M. D.
Address Mercy Hosp. Date signed 1-30-44

VS 180

13570
48052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131R

✓ G 13570

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 5243 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Benjamin Barnes
3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Doris Barnes
6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years: 30 | Months: | Days: | If less than one day: hr. min.

9. Birthplace Ill. (Town, county, and state)
10. Usual Occupation Race track
11. Industry or business

FATHER
12. Name Henry Barnes
13. Birthplace Tenn.

MOTHER
14. Maiden Name Minnie Downey
15. Birthplace Tenn.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Ceme.
Location .....

18 (a) Funeral director C. Vernon Zimmerman.
(b) Address 4611 Park Heights Ave.

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1944 at 10 A.M. 25

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1944 to Jan. 28 1944 and that I last saw him alive on Jan. 28 1944.

Immediate cause of death
Uremia
Due to chronic glomerular
Due to nephritis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature John R. Birmingham M. D.
Address JNH. Date signed .....

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G 13571
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland
(c) Hospital or institution:
West Balt. Genl Hosp. 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 556 RADNOR Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE E. FICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Frederick C. Fick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-90

8. AGE: Years	Months	Days	If less than one day
53	8	5	hr. min

9. Birthplace Baltimore Md
(City, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name August Doell
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Dora Volkmann
15. Birthplace Baltimore Md

16 (a) Informant Frederick C Fick
(b) Address 556 Radnor Ave

17 (a) Burial (b) Date thereof Feby 2/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry A. Almarock
(b) Address 4204 Ridgewood Ave

1944 2/4
(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1944 at 7:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased ~~from~~ on 1/30 19 44 to 19 .
and that I last saw her alive on 1/30 19 44.

Immediate cause of death Pulmonary Edema — Duration

Due to Cong Heart Failure

Due to

Other Conditions Anasarca Ascites
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. M. Friedman M. D.
Address West Balt Genl Hosp Signed 1/29/44

is especially important. Physicians: please write the causes of death clearly and legibly.

13572 GOERING ✓ G 13572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3903 Gwynn Oak Ave.
(c) Hospital or institution: Mt. Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Gwynn Oak Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Florence M. Goering

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Arnold Henry Sr.

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 10, 1881

8. AGE: Years 62 63 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Jenkintown Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry C. Peckham
13. Birthplace Mass.

MOTHER
14. Maiden Name Clara V. Eagin
15. Birthplace Philadelphia, Pa.

16 (a) Informant Arnold H. Goering Sr.
(b) Address 3903 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) 1-21-1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1944 at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1944 to 1/25 1944 and that I last saw her alive on 1/25 1944

Immediate cause of death: Diabetes Coma

Due to (b) Pt. dead on arrival at hospital

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None.

Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J. Davies M. D.

Address 800 W 33rd St. Date signed 1/26/44

Correct age is especially important. Physicians: please write the cause of death very plainly.

3573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G 13573
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 E. Clement St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 E. Clement St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amalia Retz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Edward Retz.

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) October 8-1880

8. AGE: Years 63 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Sofied Luedtke

13. Birthplace Poland

MOTHER 14. Maiden Name Anna Fisher

15. Birthplace Poland

16 (a) Informant Edward Retz

(b) Address 1614 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-44 (Month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cemetery

Location Brooklyn, B.A.Co., Md

18 (a) Funeral director Thos. J. Fleming

(b) Address 1426 Light St.

19 (a) FEB 1 - 1944 (Date rec'd by registrar) (b) Huntingtown Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29 1944, at 11:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1943, to June 29 1944, and that I last saw he alive on June 29 1944.

Immediate cause of death
Mitral Regurgitation Thrombus
Due to Rheumatic nephritis
Due to Auricular fibrillation

Other Conditions
(Include pregnancy within 3 months of death)

Duration
1 mo.
1 mo
1 mo
1 mo

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Ga Stearns

Address 78 Hanford Date signed M. 31. D. 44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

13574 1 X ✓ G 13574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Dundalk - Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 German Hill Rd (If rural give location)
(e) Citizen of foreign country? ——— (Yes or No) If yes, name country

3 (a) FULL NAME JAMES EDWARD BLACKMON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1943

8. AGE: Years	Months	Days	If less than one day
	1	6 3	hr min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Blackman
13. Birthplace S. C.

MOTHER
14. Maiden Name Eutah Killough
15. Birthplace S. C.

16 (a) Informant Mrs James Blackman
(b) Address 225 German Hill Rd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Kershaw Cemetery
Location South Carolina

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE & BROADWAY

19 FEB 1 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31, 1944 at 5 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6, 1944 to Jan 31, 1944 and that I last saw him alive on Jan 31, 1944.

Immediate cause of death Resp. Failure — Duration
Due to Dehydration
Due to Cardiac Prematurity
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. Tenney, M.D.
Address Mercy Hosp Date signed 1/31/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Q 13575

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

76a

Registered No. G 13575

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Pierce St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ruth Green

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-7457

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1910

8. AGE: Years 33 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Shelby, N.C.
(Town, county and state)

10. Usual Occupation Waitress

11. Industry or business Restaurant

FATHER
12. Name Henry N. Green
13. Birthplace N.C.

MOTHER
14. Maiden Name Georgie Hoyle
15. Birthplace N.C.

16 (a) Informant Georgie H. Green (mother)
(b) Address Shelby, N.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Philadelphia
Location Shelby, N.C.

18 (a) Funeral director John M. Johnson
(b) Address 1620 Druid Hill Ave

19 (a) FEB 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1944, at 11:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1943 to Jan 29 1944 and that I last saw her alive on 1-29 1944.

Immediate cause of death	Duration
Primary Anemia	
Due to Agranulocytosis	
Due to Unknown origin	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1552 Druid Hill Ave Date signed 1-31-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G 13576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 12

G 13576 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 Druid Hill ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 Druid Hill ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Rider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1845

8. AGE: Years	Months	Days	If less than one day
98	10	12	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace Md

MOTHER
14. Maiden Name Eliz Sanden
15. Birthplace Md

16 (a) Informant Lottie V S Wellin
(b) Address 2027 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1050 W Montgomery St

19 (a) Date rec'd by Reg. FEB 1 1944 (b) Huntington Williamson MD

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1944 at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 - 1944 to Jan 28 1944 and that I last saw him alive on Jan 28 1944.

Immediate cause of death Mitral insufficiency — Duration Con. Unknown

Due to Arteriosclerosis — Duration Con. Unknown

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George H. Pond Jr M. D.
Address 1632 Druid Hill Ave Date signed 1-31-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 B

✓ G 13577 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W Broadway
(c) Hospital or institution: Church Home - Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 North Caey St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Wm. James Hooper (CLAUDE S. COOPER)

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 170-20-1680

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mrs. Grace Cooper

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1884

8. AGE: Years 59 | Months 5 | Days 26 | If less than one day: hr. ____ min

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

MOTHER - FATHER

12. Name Thomas Cooper

13. Birthplace Pennsylvania

14. Maiden Name Hortense Usted

15. Birthplace Pennsylvania

16 (a) Informant Grace Cooper

(b) Address 22 N Caey St

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month, day, year)

(c) Cemetery or crematory Mikvo-Israel

Location Mikvo-Israel

18 (a) Funeral director Milton Otten

(b) Address 1217 N Fond St

19 FEB 1 - 1944 (Date rec'd by registrar) (b) Harrington for Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1944 at 7:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1944 to Jan 31 1944, and that I last saw him on alive on Jan 31 1944.

Immediate cause of death: Uraemia — Duration

Due to Carcinoma of prostate & pyonephrosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sol Goldberg M. D.

Address Church Home & Hospital Date signed 2/1/44

13578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 C

G 13578 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 N. Eutaw St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 N. Eutaw St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Frederick Leasner

3 (b) If veteran, name war N | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Annie E.
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1894

8. AGE: Years	Months	Days	If less than one day
49	1	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Musician
11. Industry or business

FATHER 12. Name George Frederick Leasner Sr
13. Birthplace Baltimore

MOTHER 14. Maiden Name Annie S Reckels
15. Birthplace Baltimore

16 (a) Informant Son, Charles Frederick
(b) Address 257 N. Fulton Ave, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Millhouse & Son
(b) Address 1219 E Fayette St

19 (a) 2-1-1944 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to Jan 31 1944 and that I last saw h[illegible] alive on Jan 31 1944.

Immediate cause of death: Cirrhosis of liver — Duration

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Herman Williams M. D.
Address 714 N. Howard St Date signed Jan. 31, 1944

VS 150

G 13579

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13579 Registered No. 1210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mrs Mary Miller
3 (b) If veteran, name war W
3 (c) Social Security Account No. NONE
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. ?
6 (b) Name of husband or wife ?
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 2nd 1866
8. AGE: Years 78 Months 2 Days 28 If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Peter Meyer
13. Birthplace Germany
MOTHER 14. Maiden Name Mary Rausch
15. Birthplace Germany
16 (a) Informant Records City Welfare Dept
(b) Address
17 (a) Burial (b) Date thereof 2/2/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md
18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St
19 (a) FEB 1 - 1944 (Date rec'd by registrar) (b) Registrar [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30th 1944, at 3:45 a. M
21. I certify that death occurred on the date above stated, that I attended deceased from Feb 6 1941 to Jan 30 1944
and that I last saw h er alive on Jan 30 1944
Immediate cause of death Uremia Myocarditis
Due to
Due to
Other Conditions Arteriosclerosis Senescence
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: unkn

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature]
Address 1720 W. 25th St Date signed Jan 31 1944

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 13580

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 N. WASHINGTON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME G. Thomas Francis

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 215-07-6072

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th 1913

8. AGE: Years 30 31 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Asst Manager

11. Industry or business Equitable Trust Co.

FATHER
12. Name Nelson Francis
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Wesley
15. Birthplace Md.

16 (a) Informant William Francis
(b) Address 4338 Berger Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md.

18 (a) Funeral director Wilkerson Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 1 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 31 1944 at 2:38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 4 1944 to 1 - 31 1944 and that I last saw h. l. alive on 1 - 31 1944

Immediate cause of death: Chronic nephritis — Duration 12 yrs.

Due to

Due to Chronic osteomyelitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klipinowa
Address St Joseph's Hospital Date signed 1-31-44 M.D.

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C 13581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. C 13581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Havenwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 -
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hammer

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1886

8. AGE: Years	Months	Days	If less than one day
58 57			hr. min.

9. Birthplace Balto. Md. (Town, county, and State)
10. Usual Occupation Stationary Engineer
11. Industry or business Henlein Bros.

FATHER
12. Name George Hammer
13. Birthplace Unknown

MOTHER
14. Maiden Name Theresa "
15. Birthplace "

16 (a) Informant Otto V. Braun
(b) Address 2516 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st.

19 (a) FEB 1 - 1944 (Date received by registrar)
Huntington Millard Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 1943, to Jan 30 1944, and that I last saw him alive on Jan 30 - 1944.

Immediate cause of death: Coronary Occlusion — Duration 6 mos.
Due to Chronic Arteriosclerosis — 2 yrs.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Hoyer MD
Address 1516 N. Mitchell Ave Date signed 1/31/44 M. D.

G 13582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13582 Registered No. 128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3418 Elliott ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Elliott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Nitscher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	M.

6 (b) Name of husband or wife AMELIA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
92	10	8	hr. min

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY

16 (a) Informant MRS. ARTHUR COLEMAN
(b) Address 3418 ELLIOTT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location 7225 EASTERN AVE

18 (a) Funeral director Clarence P Hoffmann
(b) Address 1639 N. BROADWAY

19 (a) FEB 1 - 1944 (Date rec'd by registrar) (b) Justin for Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1944 at 10 25 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage

Due to

Other Conditions Chronic pulmonary tuberculosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner
Date signed Jan. 30 1944

13583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 13583 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address No. 2117 Etting St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Etting St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Palmer

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1895

8. AGE: Years 48 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Chas. Harris
13. Birthplace Va

MOTHER
14. Maiden Name unobtainable
15. Birthplace

16 (a) Informant Riley Palmer
(b) Address 2117 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Guy H. Kelly
(b) Address 1303 Pleasant St.

19 FEB 1 - 1944 (Date rec'd by registrar) Registrar for Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1944 at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1944 to 1/30 1944 and that I last saw h alive on 19

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 234 Bond St Date signed

G 13584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13584 Registered No. 1180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Etting Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GLORIA WATKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/2/43

8. AGE: Years	Months	Days	If less than one day
1	-	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Norman Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Priscilla Watkins
15. Birthplace Md

16 (a) Informant Priscilla Watkins
(b) Address 2210 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pleasant St.

19 (a) FEB 1 - 1944 (Date rec'd by registrar) (b) Martin Von Willis Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1944, at 6:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation

Due to House afire

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-31-44 at 4:40 P.M.
(b) Where did injury occur? 2210 Etting Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Suffocation due to house afire.

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.
Date signed 1-31-44

13585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13585
Registered No. 180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME PAUL-ROOSEVELT- TONEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1/42

8. AGE: Years 1 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md (town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Paul Toney
13. Birthplace Md

MOTHER
14. Maiden Name Maynar Adams
15. Birthplace md

16 (a) Informant Marion Toney
(b) Address 2210 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pleasant St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1944 at 6:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation

Due to House afire

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-31-44 at 5:40 A. M. 14/3
(b) Where did injury occur? 2210 Etting Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocation due to house afire.

23. Signature T. J. Wollenweber M.D.
Medical Examiner.
Date signed 1-31-44

VS 151

D 48 G 13586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH / 93 Y

G 13586
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 E Lombard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 - 1 - 88

8. AGE: Years	Months	Days	If less than one day
56	-	24	hr. min.

9. Birthplace N.C
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Ray Davis
13. Birthplace N.C.

MOTHER
14. Maiden Name Lena Saunders
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Broadway

19 (a) FEB 1 - 1944 (b) Hunting ton Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 25 1944 at 920 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 23 1944 to JAN 25 1944 and that I last saw her alive on JAN 25 1944.

Immediate cause of death	Duration
Pneumococcus meningitis	
Due to Pneumococcus septicemia	
Due to	
Other Conditions Hypostatic congestion - pneumonia etc.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Clark Hough M. D.
Address Johns Hopkins Date signed 4/5/44

Physicians are especially important. Please write the causes of death clearly and legibly.

44791

G 13587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13587

Registered No. 1210

1. PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1727 Jefferson St (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Benson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-05

8. AGE: Years	Months	Days	If less than one day
35	8	2	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Benson
13. Birthplace Md

MOTHER
14. Maiden Name Susie Antisant
15. Birthplace Md

16 (a) Informant records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/44 (month) (day) (year)

(c) Cemetery or crematory McKeldin
Location

18 (a) Funeral director Evan Wilson
(b) Address 1000 Brantley Ave

19 (a) B.C. - 1944 (Date rec'd by registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1944 at 1 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1944 to Jan 30 1944, and that I last saw him alive on Jan 30 1944.

Immediate cause of death Uremia — Duration 1 mos.

Due to Nephrosclerosis

Due to Arteriosclerosis with Malignant Hypertension 5 mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Abraham Cohen M. D.

Address J. Hopkins Date signed 1-30-44

G 13588 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
G 13588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 W. Ostend St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred Allen Conquest
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife 1960
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 75 | Months | Days | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name not none
13. Birthplace " "

MOTHER
14. Maiden Name not none
15. Birthplace " "

16 (a) Informant Alfred Conquest Son
(b) Address 820 W Ostend St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location
18 (a) Funeral director Elroy O Wilson
(b) Address 1000 E Brantley
19 (a) 1-1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1944, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L Feehan M.D. Medical Examiner.
Date signed January 29 1944

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G 13589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13589 Registered No. 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 N. Bond St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophia Booker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife Grant. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1878

8. AGE: Years 65 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Domestic
11. Industry or business at Home

FATHER 12. Name George W. Stevens
13. Birthplace Md.

MOTHER 14. Maiden Name Henretta Gibson
15. Birthplace Md.

16 (a) Informant Marion Crapper
(b) Address 517 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1008 Bradley ave.

19 (a) FEB 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1944, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1942 to Jan 26 1944, and that I last saw h[er] alive on Jan 26 1944.

Immediate cause of death Bronchopneumonia
Due to Carcinoma of breast
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 4 days 4 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert C. Lefevre M. D.
Address 522 N. Bond St Date signed 1/29/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13590 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 774 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 774 W. Saratoga St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-8843

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
41 40			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas C. Hammond
13. Birthplace Fredrick, Md.

MOTHER
14. Maiden Name Josephine Holland
15. Birthplace Md.

16 (a) Informant Margorie Brown
(b) Address 774 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) FEB 1 1944 (b) (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29/44 at 9h M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 19 44 to 1/29 1944 and that I last saw h alive on 1/28/44

Immediate cause of death: Lobar Pneumonia — Duration: 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Waldeone M. D.
Address 1131 Harlem Ave. Date signed 1/31/44

Please write plainly. Physicians: please write the causes of death clearly and legibly. Information must be complete and correct age is especially important.

G 13591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13591

Registered No. 1318

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: Lewith Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 E Baring St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie C. Hyde.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	W

6 (b) Name of husband or wife Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/14/1881

8. AGE: Years	Months	Days	If less than one day
56	5	17	hr. min.

9. Birthplace Salem. (Town, county, and state)

10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Michael Kyle
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Bill
15. Birthplace Eng

16 (a) Informant Family
(b) Address 118 E. Baring St.

17 (a) S- (Burial, cremation, or removal) (b) Date thereof 2-3-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director J. L. Kennedy
(b) Address 130 E. Fayette.

19 (a) 2-1-1944 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31 1944, at 9:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18 1944, to 1-31 1944, and that I last saw her alive on 1-31 1944.

Immediate cause of death: Chronic nephritis.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. MacDonald M. D.
Address 1213 Light St. Date signed 1-31-44

VS 3

G 13592

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13592 / 122B

Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNER & DUKELAND
(c) Hospital or institution: WEST BALT. GENL HOSP. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3137 KESWICK RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN P. HURD

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-9054

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife LULA M. HURD.
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) DEC 25, 1879

8. AGE: Years	Months	Days	If less than one day hr.	min.
64	1	6		

9. Birthplace PENNSYLVANIA. (Town, county, and state)
10. Usual Occupation STATIONARY ENGINEER.
11. Industry or business WEST BALTO HOSP.

FATHER
12. Name JOHN P. HURD
13. Birthplace IRELAND.

MOTHER
14. Maiden Name BRIDGET HOOLAHAN
15. Birthplace IRELAND.

16 (a) Informant LULA M. HURD.
(b) Address 3137 KESWICK ROAD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB 3/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location

18 (a) Funeral director Thos. A. Dorsey & Son
(b) Address 3615-17 Christian St.

FEB 1 - 1944 (Date Received by Registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31/44 19 at 12 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22/44 19 to 1/31 19 44
and that I last saw h(im) alive on 1/21 19 44

Immediate cause of death UREMIA — Duration

Due to CONG HEART FAILURE & RENAL INSUFFICIENCY

Due to

Other Conditions Pulm Edema ANASARCA → Anasarca
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. N. Friedman M.D.
Address WBGH Date signed 1/21/44

A13593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13593
Registered No. 119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in ~~Baltimore~~ (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Carroll
(c) City or town New Windsor, Route #1
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY ROBERTSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 6, 1944

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Russell Robertson
13. Birthplace Maryland

MOTHER
14. Maiden Name Vital Crissinger
15. Birthplace Florida

16 (a) Informant Russell Robertson
(b) Address Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory Burial
Location Stone Chapel.

18 (a) Funeral director H. Bankard & Sons
(b) Address Westminster

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1944 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13, 1944 to Feb 1, 1944 and that I last saw her alive on Feb 1, 1944.

Immediate cause of death	Duration
Pulmonary edema and atelectasis	1 day
Due to Infantile Diarrhea	5 days
Due to Premature Birth	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm E. Steele, M. D.
Address Univ. Hosp. Date signed 2-1-44

VS 180

Physicians: please write the causes of death clearly and legibly. Information is especially important. correct age is especially important.

G 13594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 D G 13594

X484680

PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 226 Pierce St. 629
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

V

3 (a) FULL NAME
Phillip Pierce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb ? 1887

8. AGE: Years	Months	Days	If less than one day
56?	? 11	?	hr min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Louis Pierce
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Walker
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 2/3/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto Natl Cem.
Location Balto. Md.

18 (a) Funeral director Chas. G. Corbin
(b) Address 517 N. Carrollton Ave.

Thurlington Williams, M.D.
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1944 at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 1943 to 1/23 1944 and that I last saw him alive on 1/23 1944

Immediate cause of death
Bronchopneumonia — Duration 6 d.

Due to

Due to

Other Conditions HCVD ; cys-titis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. L. Seyman M. D.

Address BCH Date signed 1/25

Registered 1944

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as accurately as the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13595

Registered No.

XA-85609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete as possible. Do not use abbreviations. Cemetery supplies No. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Belto.

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 613 Baltimore St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Stanley Szymaniak

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. ?, 1887

8. AGE: Years	Months	Days	If less than one day hr.	min.
56	? 4	?		

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Dishwesher

11. Industry or business American Grill

FATHER

12. Name Joseph Symaniak (d)

13. Birthplace Poland

MOTHER

14. Maiden Name Napomancy Koskask (d)

15. Birthplace Poland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL 1 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) FEB 1 1944 Huntington Williams M.D.

(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1944 at 7:45 A

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1943 to 1/25 1944 and that I last saw him alive on 1/25 1944.

Immediate cause of death Coronary Thrombosis; Bronchopneumonia of stomach; Pulmonary edema.

Due to Hyp. arteriosclerosis

Due to A-S. CKD.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. L. Sargman M.D.

Address BCH Date signed 1/31

10698

Spec.—1-12-23—M&T—500 Blks.

13596 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G 13596

CERTIFICATE OF DEATH. 159

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) 154 W. Cross ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Davis

(a) RESIDENCE No. 154 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE N. | 5 Single, Married, Widowed, or Divorced, (write the word) S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days: 24 hrs | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Alex Davis

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Baylor

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant Martha Davis
(Address)

15 FEB 1 1944 Filed Huntington Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/1 1944

17 I HEREBY CERTIFY, That I attended deceased from 1/31 1944 to 2/1 1944

that I last saw h[illegible] alive on 1/31 1944

and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity (5 mos)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. N. Taylor M. D.

2/1 1944 (Address) 1522 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHN HOPKINS MEDICAL SCHOOL — DATE OF BURIAL FEB 1 1944

20 UNDERTAKER Commissioner of Health — ADDRESS

0699

G 13597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. 26881 G

PLEASE WRITE PLAINLY, with UNFADING INK. Entry must be made on this certificate before burial or removal from city or town where death occurred, and must be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 E. 21st St
(c) Hospital or institution: * * *
(d) Length of stay in hospital or inst. (yrs., mos., or days) *
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County * *
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 E 21st Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country * * *

3 (a) FULL NAME Catherine T. O'Brien

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Frank O'Brien

6 (c) If alive, give age 72 yrs.

7. Birth date of deceased (mo., day, yr.) May 16 - 1864

8. AGE: Years 79 | Months 8 | Days 23 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John D. O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. Callagher
15. Birthplace Ireland

16 (a) Informant Miss. Nellie O'Brien
(b) Address 712 E 21st St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) FEB 1 - 1944 (Date received by registrar) Wm. H. Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1944 at 2-16 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 - 1943 to Jan 29 1944, and that I last saw her alive on Jan 25 1944.

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Mitral Stenosis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed Jan 29 44

G 13598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13598 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made on this certificate before any copies are made. Use typewriter if possible. Do not abbreviate. Give exact street address or location. Be sure that the entry for each item is complete and correct. Do not leave any items blank. If unknown, or if not applicable, write "unknown" or "N. A." The space for "Length of stay" should be filled in for all deaths occurring in hospitals or institutions. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2010. PARK AVE.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND. (b) County
(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2010. PARK AVE. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN JOSEPH MURPHY.

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	Male	White	Married

6 (b) Name of husband or wife: Marie Brown Murphy
6 (c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): Nov. 18-1944 1889

8. AGE: Years	Months	Days	If less than one day
55	2	10	hr. min

9. Birthplace: Baltimore, Maryland (Town or county, state)
10. Usual Occupation: Sales manager
11. Industry or business: Advertising.

FATHER
12. Name: Michael Moses Murphy
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Bridget O'Reilly
15. Birthplace: Ireland

16 (a) Informant: Lewis M. Hayden
(b) Address: 2010 Park Avenue

17 (a) Burial (Burial, [redacted]) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Old Frederick Road

18 (a) Funeral director: CHAS. F. EVANS & SON
(b) Address: 118 W. Mt. Royal Ave

FEB 1 - 1944 (b) [redacted] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH JANUARY 29 19 44 at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from JANUARY 28. 44 to JAN. 29 19 44
and that I last saw h[illegible]M alive on JAN 29 19 44

Immediate cause of death	Duration
ANGINA PECTORIS JANUARY 28.	1944
Due to ARTERIOR SCLEROSIS	1943
Due to CHRONIC MYOCARDIAL DEGENERATION.	1943.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 3013 ST PAUL ST. Date signed 1/29/44

3599

G 13599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.,
(c) Hospital or institution: St. Joseph's Hospital 919
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Quarrick 21835

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles S. Quarrick
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 5, 1916
8. AGE: Years 27 | Months 6 | Days 26 | If less than one day: hr. min.
9. Birthplace: Union Town Penn. (Town, county and state)
10. Usual Occupation: House work
11. Industry or business: at Home

FATHER
12. Name: Frank J. Barbazet
13. Birthplace: Europe

MOTHER
14. Maiden Name: Elizabeth H. Walbert
15. Birthplace: Emerson Penn.

16 (a) Informant: Mr. Charles S. Quarrick
(b) Address: 1110 Webb Court.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 4, 1944 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's Cemetery
Location: Union Town Penn.

18 (a) Funeral director: Edmund W. Courtney Jr.
(b) Address: 924 N. Eutaw St.

FEB 1 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1944, at 5: A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1944 to 2/1 1944.
and that I last saw her alive on 2/1 1944.

Immediate cause of death: Pregnancy — Duration: 7½ mo.
Due to:
Due to:
Other Conditions: Chronic Nephritis, Hypostatic Pneumonia
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

over

1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. B. Bellows M. D.
Address: St. Joseph's Hosp. Date signed

2/1/44

PLEASE WRITE IN PENCIL. Physicians: please write the causes of death clearly and legibly. Accurate and correct age is especially important.

G 13600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13600 Registered No. 1142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Brighton St. (If rural give location)
(e) Citizen of foreign country? Yes or No) If yes, name country

3 (a) FULL NAME David B. Gambrill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife Della Gambrill
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Dec. 29. 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
68	1	3		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Upholsterer
11. Industry or business

FATHER
12. Name Henry Gambrill
13. Birthplace Va.

MOTHER
14. Maiden Name Laura Valentine
15. Birthplace Va.

16 (a) Informant Mrs. Della Gambrill
(b) Address 3017 Brighton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4. 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3707 W. North Ave
(c) Washington Williams Undertaker

19 (a) (Register

FEB 1 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1 1944, at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1943, to 2/1 1944, and that I last saw him alive on 1/31 1944.

Immediate cause of death Cachexia — Duration

Due to lung abscesses & chronic cholelithiasis

Due to

Other Conditions Benign prostatic hypertrophy (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: lung abscesses cholelithiasis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. H. Stewart Jr. M. D.
Address Mt. Hosp Date signed 2/1/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13601

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a

Registered No. G 13601

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 N. Ellwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 N. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Badolato

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20. 1944

8. AGE: Years	Months	Days	If less than one day
		12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Anthony U. Badolato
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Antoinette Cieri
15. Birthplace Baltimore Md.

16 (a) Informant Anthony U. Badolato
(b) Address 1406 N. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2. 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) Feb 1 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1. 1944, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1944 to Feb. 1 1944, and that I last saw him alive on Feb. 1 1944.

Immediate cause of death: atelectasis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations:

of autopsy:

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C. Schibal
Address 4474 Kenwood Ave Date signed 2/1/44 (M. D.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erasures must not be made. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

13602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13602
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Carrollton Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE EDWARD WALTERICK

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1886

8. AGE: Years	Months	Days	If less than one day
57	2	30	hr. ____ min.

9. Birthplace Chambersburg, Pa.
(Town, county, and state)
10. Usual Occupation None for past 2 years
11. Industry or business -

FATHER
12. Name Charles Walterick
13. Birthplace Chambersburg, Pa.

MOTHER
14. Maiden Name Margaret Silvers
15. Birthplace Chambersburg, Pa.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-44 (month) (day) (year)
(c) Cemetery or crematory
Location Hagerstown Md

18 (a) Funeral director C. Lee Ogden
(b) Address 4644 York Rd

19 (a) (Date received by registrar) Harrington Williams M.D. (Registrar)

FEB 2 - 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25, 1944 to Jan. 31, 1944, and that I last saw him alive on Jan. 31, 1944.

Immediate cause of death 1. Uremia due to bilateral hydronephrosis; 2. Bilateral pulmonary congestion, edema, and bronchial pneumonia — Duration: Unk.

Due to — Unk.

Other Conditions — over

(Include pregnancy within 3 months of death)

Date of operation 1/26-Suprapubic cystotomy

Major findings of operation: Uremia

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Specify) (Specify)
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore, Md. Date signed 2/1/44

Va-14255

G 13603

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 Registered No. G 13603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2322 Division St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2322 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Hines

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	wid Dom.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Statesville, N. Carolina (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business
FATHER 12. Name Franklin Jones
13. Birthplace Statesville, N.C.
MOTHER 14. Maiden Name Amanda Hinton
15. Birthplace Statesville, N.C.
16 (a) Informant Ethel Saunders
(b) Address 711 Mother St.
17 (a) (Burial, cremation, or removal) (b) Date thereof 2-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore, Md.
18 (a) Funeral director Charles H. C. Haddis
(b) Address 2101 McCulloh St.
19 FEB 2 - 1944 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1944, at 11:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1944 to Jan 29 1944, and that I last saw her alive on Jan 29 1944.

Immediate cause of death: Bronchopneumonia — Duration: Jan 29
Due to: Hypostatic Congestion
Due to: Diabetes — 3 months
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Nathan Higgins M. D.
Address 243 Madison Ave Date signed 2-2-44

Correct age is especially important. Physicians, please

VS 3

13604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13604
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-0-29
(e) Length of stay in Baltimore (yrs., mos., or days) 7-0-29

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town West Chester
(If outside city or town limits, write RURAL and give town)
(d) Street No. Villa Maria
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister M. Narcissa Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1890

8. AGE: Years 53 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Gordon, Penna
(Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-1944 (month) (day) (year)
(c) Cemetery or crematory Immaculata Cemetery
Location West Chester, Penna.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) FEB 2 - 1944 (Date rec'd by registrar) (b) Clinton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1944, at 6-15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1937 to Feb. 1 1944, and that I last saw h.e.r. alive on Feb. 1 1944.

Immediate cause of death: Acute circulatory collapse — Duration: 2 days
Due to: Psychosis with epidemic encephalitis — 7 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

correct age is especially important. Physicians: please answer all questions.

VS 8

13605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 13605

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hirshfield Kahn & Co.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Ingelside Ave (If rural give location)
(e) Citizen of foreign country? Ingelside (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Sandekoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1886

8. AGE: Years	Months	Days	If less than one day
57 58	10	15	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name Joseph Sandekoff
13. Birthplace Russia

MOTHER
14. Maiden Name Sylvia
15. Birthplace Russia

16 (a) Informant Harvey Silberg
(b) Address 3210 Ingelside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem.
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) 2/2/44 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1944, at 3:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frater M.D.
Medical Examiner.
Date signed February 1, 1944

VS 151

G 13606 Davis

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13606 Registered No. 12 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun Mfg Fayette 20
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 S. Poppleton St (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Annie D. Davis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Thomas D. Davis
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9/22/1876

8. AGE: Years 67 | Months 4 | Days 38 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER 12. Name Charles Rueschmitzer
13. Birthplace Germany

MOTHER 14. Maiden Name Annie Gerhardt
15. Birthplace Germany

16 (a) Informant Mrs. Deems
(b) Address 23 S. Poppleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director H. D. Shipley & Son
(b) Address 1400 Pennsylvania Ave

FEB 2 - 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1943 to 1/30 1944 and that I last saw h[illegible] alive on 1/29 1944.

Immediate cause of death — Duration
Uraemia — 3 week
Due to Chronic Nephritis — 1942
Due to Coronary Thrombosis — 5 week
Other Conditions
Cardiac Decompensation

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Caplan M. D.
Address 2145 W Balto Date signed

correct age is especially important. Physicians, please

VS 2

13607

CAVANO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G 13607
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chapelgate Lane
(c) Hospital or Institution: Crescent Sanitarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Shelley Rd (If rural give location)
(e) Citizen of foreign country? Chelsea (Yes or No)
If yes, name country

3 (a) FULL NAME George E. E. Cavano

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Annie R. Cavano

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 25-1861

8. AGE: Years 82 | Months 3 | Days 3 | If less than one day ... hr. ... min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name Louis Cavano
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Brown
15. Birthplace Maryland

16 (a) Informant Mrs Wilmer Attwood
(b) Address 2909 Shelley Rd

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/3/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. D. Shepherd Son
(b) Address 1310 Eutaw Place

19 (a) Date received by registrar FEB 2 — 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31st 1944, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1944 to 1/31 1944, and that I last saw him alive on 1/31/44 1944

Immediate cause of death

	Duration
Due to Repeated Coronary Thrombosis	10 days
Due to Arteriosclerosis	
Other Conditions Chronic nephritis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. P. Alagia M. D.
Address 536 Fredericks Ave Date signed 2/1/44

Correct age is especially important. Physicians: please write plainly.

D. P. ALAGIA

13608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

✓ G 13608

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore #24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Hoffman Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hunt, Mr Oswald (OSWALD HUNT)

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-12-9649

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs Edith Hunt
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1889

8. AGE: Years	Months	Days	If less than one day hr	min.
54	3	28		

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Sr. Checker, Receiving Dept.
11. Industry or business Camp Holabird, Md.

FATHER
12. Name Hunt, Benjamin F.
13. Birthplace Maryland

MOTHER
14. Maiden Name Lemmon Ida
15. Birthplace Maryland

16 (a) Informant Mrs Edith Hunt
(b) Address 1214 Hoffman Ave. Balt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

FEB 2 - 1944 (Date rec'd) (Huntington or Williamsport, Ind.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1944 at 4:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1944, to 1-30 1944, and that I last saw him alive on 1-30 1944.

Immediate cause of death: Cerebral Hemorrhage (Portal)
Duration: 9

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-22-44

Major findings of operation: As above

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M. Cullen M. D.
Address Church Home & Hospital Date signed 1-30-44

correct age is especially important. Physicians: please write

13609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13609

Registered No. 43a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 Division St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ladie Christer

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-29-1889

8. AGE: Years 54 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Paul Harrison.
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Harry Christer.
(b) Address 1730 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna. ave

19 FEB 2 - 1944 (Date Rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1944 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29 1944 to 1/30 1944 and that I last saw h alive on 1/29 1944. H

Immediate cause of death Cerebral Hemorrhage

Due to Left sided Paralysis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.

Address 113 Harlem Md Date signed 1/31/45

VS 180

13610 Mt. Hilary.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13610
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 Mc Kean Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Mc Kean Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs. Ella Virginia Knapp (nee Shoemaker)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frederick Knapp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14-1874

8. AGE: Years	Months	Days	If less than one day
70	0	12	hr. min.

9. Birthplace Sammytown, Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Wm. H. Shoemaker
13. Birthplace Sammytown, Md.

MOTHER
14. Maiden Name Laura Martin
15. Birthplace Penna.

16 (a) Informant Miss Gladys Knapp.
(b) Address 1537 Mc Kean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 4 (day) 44 (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Wm. Weber & Son
(b) Address 2503 Edmondson Ave.

19 (a) 2-1944 at writer's for Williamsport, Md.
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 1944, at 9.30 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1 1944 to Jan 31 1944 and that I last saw h[illegible] alive on Jan 31 1944

Immediate cause of death Cardiac Failure — Duration 5 yrs

Due to Arterio Sclerosis — Duration 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Gorsuch M.D.
Address 6222 N. Rockdale Date signed 2/6/44

13611 Silver 13611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3015 Abell ave St., 7 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME William Finney Silver

If U. S. Veteran specify WAR .....

(a) Residence: No. 3015 Abell ave St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

6a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Anna B Silver (Dec'd)

6. DATE OF BIRTH (month, day, year) Jan 17-1859

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
85	0	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Foreman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Steel Works

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) W. Va.

FATHER

13. NAME Sylvester A Silver

14. BIRTHPLACE (city or town) (State or country) Harford Co Md

MOTHER

15. MAIDEN NAME Rebecca Bonsall

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT Mrs. Gracie P Dever

(Address) 3015 Abell Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Harmony Cem Date 2-3-44

19. UNDERTAKER Pennington & Son

(Address) Avenue de Grace Md

20. FILED 2-1944 Pennington Williamson Mortuary

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 31, 1944

22. I HEREBY CERTIFY, That I attended deceased from June, 1943 to Jan 31, 1944

I last saw him alive on Jan 28, 1944 Death is said to have occurred on the date stated above, at 11:55 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypostatic Congestion Pneumonia	
Disease	1 yr
Other contributory causes of importance:	

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? Clinical Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify .....

(Signed) Fritz D Schnizer M. D.

(Address) 2700 Harford Road

OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

VS 3

G 13612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a ✓ G 13612 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Oakley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Harry 3 Solomon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife Nov 28 - 43

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 2 | Days: 3 | If less than one day: hr. min

9. Birthplace Frederick Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Harry S Solomon
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Bida Hoffmeister
15. Birthplace Brunswick Md

16 (a) Informant Harry S Solomon, Sr
(b) Address 3109 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

FEB 2 - 1944 (a) (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1944, at 4:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9. 1944 to Feb. 1 1944. and that I last saw him alive on Feb. 1 1944.

Immediate cause of death: Scleroma — Duration: 2 days
Due to Dehydration
Due to Infantile Diarrhea

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Haught
Address Univ. Hosp. Date signed 2/1/44 (M. D.)

VS 160

Coroner's age is especially important. Physicians, please write the cause of death clearly and legibly.

13613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G 13613

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 N. Cold Spring Lane

(c) Hospital or institution: Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3904 Falls Road (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME George Sylvester Sykes

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella Louise Sykes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31 - 1873

8. AGE: Years	Months	Days	If less than one day
70	1	—	hr. / min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation Engineer P.R.R.

11. Industry or business Retired 3 years

FATHER 12. Name James Sykes

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Laura Dietz

MOTHER 15. Birthplace Maryland

16 (a) Informant Mrs. Ella Louise Sykes

(b) Address 3904 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3-1944 (month) (day) (year)

(c) Cemetery or crematory St. Mary's (Homeden)

Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3621 Falls Road

19 (a) FEB 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1944, at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1943 to Jan 31 1944, and that I last saw h alive on Jan 31 1944.

Immediate cause of death Cerebral hemorrhage — **Duration**

Due to

Due to

Other Conditions chronic myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. H. Cutterman M. D.

Address 2324 Reisterstown Rd Date signed 2/1/44

CORRECT AND IS CONSISTENTLY RECORDED. Physicians, please write plainly and use only black ink. Legibly.

13614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G 13614

Registered No.

Copper ink is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4837 REISTERSTOWN RD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4837 REIST RD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL DWORKIN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife PAULINE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation SHEET-METAL WORKER

11. Industry or business U.S. NAVY

FATHER 12. Name NOT KNOWN

13. Birthplace RUSSIA

MOTHER 14. Maiden Name REBECCA

15. Birthplace RUSSIA

16 (a) Informant WIFE

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-2-44 (month) (day) (year)

(c) Cemetery or crematory Sherwood Rum
Location Phil Rd. & Bowleys Lane

18 (a) Funeral director JACK LENIS INC.

(b) Address 1439 E. BALTO. ST.

19 (a) FEB 2 - 1944 (Date rec'd by registrar) (b) Registrar Wellington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1-44 19 .. at 7 A.M 30

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8- 1942 to 2-1- 1944 and that I last saw h alive on 1-30- 1944.

Immediate cause of death: Acute myocardial infarction — Cardiac failure — Duration: 1 hr.

Due to: C.C. Myocardial infarction — Duration: 1 yr.

Due to: — Duration: 19 mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius M. Wachtelstein M. D.

Address 86 Madison St. Date signed 2-2-44

WACHTELSTEIN

13615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13615

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 N. Athol Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 N. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR G. HARRISON

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Christina K.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1875

8. AGE: Years 68 | Months 10 | Days 20 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Retired Foreman

11. Industry or business

FATHER
12. Name George H. Harrison
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Johnson
15. Birthplace Md.

16 (a) Informant Mrs. Christina K. Harrison
(b) Address 8 N. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd FEB 2 - 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1944 at 12.01 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/43 19 to 1/31 1944
and that I last saw h alive on 1/30 1944

Immediate cause of death: Chronic Nephritis.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Aloha H Crowther

Address 4209 Hudson Date signed 2/1/44 M D

ALOHA H CROWTHER

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

13616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G 13616
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct; age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 435 W. Henrietta St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 435 W. Henrietta St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Ross Offer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-30-1901

8. AGE: Years	Months	Days	If less than one day
43 yrs	-	-	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alfred Ross
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annie Gray
15. Birthplace Balto. Md.

16 (a) Informant Eva Ross
(b) Address 435 W. Henrietta

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Hill St.

19 (a) FEB 2 - 1944 (Date rec'd by registrar) (b) Huntington Williams, Dep. M.C.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1944, at 1 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1944. to 1-30 1944. and that I last saw he alive on 1-30 1944.

Immediate cause of death	Duration
Pulmonary Embolism	1 day
Due to Post operative Gastric resection	10 days
Due to Gastric Ulcer	

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 1-21-44
Major findings of operation: Gastric Ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Bradshaw Higgins M. D.
Address 2243 Madison Ave. Date signed 2/2/44

C 13617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 13617

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 2 mos. 22 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 419 Merryman Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Lopez

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1903

8. AGE: Years 40 | Months 2 | Days 20 | If less than one day: hr. min.

9. Birthplace Cape Verde Island (Town, county, and state)

10. Usual Occupation Ship's cook

11. Industry or business

FATHER
12. Name Frank Lopez
13. Birthplace Cape Verde Island

MOTHER
14. Maiden Name Isabelle Andrade
15. Birthplace Cape Verde Island

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5. 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 409 Gaithmount Street

19 (a) FEB 2 - 1944 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1944 at 3:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1942 to 1-18 1944, and that I last saw him alive on 1-18 1944.

Immediate cause of death
Pulmonary TBC — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burl Platt M. D.
Address B.C.H. Date signed 1-31-44

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

M. D. H. 1268-9

13618 G 13618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 107

1. PLACE OF DEATH

Registered No. .....

CITY OF BALTIMORE: (No. 2408 Woodbrook Ave Ward) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 68 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Mathew Lupiak

(a) Residence: No. 2408 Woodbrook Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ George Lupiak

6. DATE OF BIRTH (month, day, year) Feb 1 [illegible]

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68	68	11	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) St Marys Co. Md (State or country)

FATHER

13. NAME Bernard Banks

14. BIRTHPLACE (city or town) St Marys Co. Md (State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) St Marys Co. Md (State or country)

17. INFORMANT Mrs. George Lupiak

(Address) 2408 Woodbrook Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Mount Calvary Cemetery Date February 3, 1944

19. UNDERTAKER Joseph A. Lipsky

(Address) 4699 Main Street

FEB 2 - 1944 19 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 30, 1944

22. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1943, to Jan 30, 1944

I last saw him alive on Jan 27, 1944. Death is said to have occurred on the date stated above, at 7:40 Am.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	1 hr
Other contributory causes of importance:	
Hypertension	4 mos

Name of operation None Date of

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Virgando M. D.

(Address) [illegible]

V. S. 3

Information should be carefully supplied and entered accurately. PENALTIES should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 13619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830a

G 13619
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 Ostend St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 5yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Ostend St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pius J. DeVaughn

3 (b) If veteran, name war

3 (c) Social Security Account No. 248-18-5239

4. Sex Male | 5. Color or race Col— | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ruby DeVaughn

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) May 1 1903

8. AGE: Years 40 | Months 3 | Days 30 | If less than one day ... hr. ... min.

9. Birthplace Florence Co. S. C.
(Town, county, and state)

10. Usual Occupation Long Shoreman

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Mary Hannah
15. Birthplace Florence Co. S. C.

16 (a) Informant Ruby DeVaughn
(b) Address 830 Ostend St

17 (a) Removal (b) Date thereof Feb 5. 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Florence S. C.
Location

18 (a) Funeral director Joseph A. Lively
(b) Address 408 N Mount Street

19 (c) FEB 2 1944 Huntington Williams, M.D.
Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Jan 31 1944, and that I last saw h alive on Jan 31 1944.

Immediate cause of death Cerebral Hemmorhage 1 day.

Due to Hypertension

Due to

Other Conditions Pneumonia

in December 43
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Saunders M. D.
Address 1111 Sea St Date signed 2/11/44

G 13620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

84a

G 13620 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 da.

2. USUAL RESIDENCE OF DECEASED PARENTS:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6306 Marietta Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Combs.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1944

8. AGE: Years | Months | Days: 7 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and State)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Clay Combs.
13. Birthplace

MOTHER 14. Maiden Name Helen Millholland
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Darby

18 (a) Funeral director
(b) Address

19 (a) Date received 1944 (b) Registrar Hunter Williams

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1944, at 6 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944, to Jan 22 1944, and that I last saw him alive on Jan 22 1944.

Immediate cause of death: Cardiorespiratory failure — Duration

Due to

Due to

Other Conditions: Mongolian Idiocy — Congenital

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James H. McCook Jr. M. D.
Address Union Memorial Hospital Date signed 1-22-44

G 13621

Headspeth

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

G 13621

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dock Headspeth
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Victoria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-97

8. AGE: Years 46 | Months 1-9 | Days 16 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Green Hayspeth
13. Birthplace Va?

MOTHER
14. Maiden Name Cora Bailey
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 2 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1944 at 2.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1944 to Feb. 1 1944 and that I last saw him alive on Feb. 1 1944

Immediate cause of death: pulmonary edema — Duration: 1 day

Due to: circulatory failure

Due to: Dissecting aneurysm of aorta — Duration: 2 yrs.

Other Conditions: malignant hypertension (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cohen M. D.
Address J. Hopkins Date signed 2-1-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 13622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 13622
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOE WILL HAMLET

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 23 | Months 22 | Days | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Post office

11. Industry or business

FATHER
12. Name Pat Hamlet
13. Birthplace Va.

MOTHER
14. Maiden Name Ida Hamlet
15. Birthplace Va.

16 (a) Informant John S. Davis
(b) Address Clarktown, Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/44 (month) (day) (year)
(c) Cemetery or crematory Nathalie, Va.
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) FEB 2 1944 (b) Huntington Baltimore, Md.
(Date received by Local Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1944 at 11:20 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture dislocation cervical vertebra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-30-44 11 P. M.
(b) Where did injury occur? Franklin & Greene Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Collision of two autos.

23. Signature H. L. Wollenweber M.D.
Medical Examiner
Date signed 1-31-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13623

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1464 Williams St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1464 Williams St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wesley Thomas Pope

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Margaret Erb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/12/1852

8. AGE: Years 91 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace N. Va.
(Town, county and state)

10. Usual Occupation Retired Lab'r
11. Industry or business Fireman

FATHER
12. Name Conrad Pope
13. Birthplace N. Va.

MOTHER
14. Maiden Name Mary Swarts
15. Birthplace Va.

16 (a) Informant Mrs. M. Swarts
(b) Address 1464 Williams St.

17 (a) Burial (b) Date thereof 2/3/44
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director John E. Sharp & Sons
(b) Address 318 Light St.

19 (a) FEB 2 - 1944 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1944 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 '44 to Jan 30 1944
and that I last saw h alive on Jan 24 1944.

Immediate cause of death Myocardial Insufficiency — Duration

Due to — Duration

Due to — Duration

Other Conditions Arterio Sclerosis & Hypertension — Duration
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. Schramm
Address 337 S. Charles St. Date signed 2/1/44

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 13624
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3122 ELLIOTT ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 ELLIOTT ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET POTTHAST

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: CHARLES L. POTTHAST

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JUNE 27 1872

8. AGE: Years: 71 | Months: 7 | Days: 4 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: PHILLIP TECHER
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: CHARLES L. POTTHAST (HUS.)
(b) Address: 3122 ELLIOTT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 3/44 (month) (day) (year)
(c) Cemetery or crematory: SACRED HEART
Location: GERMAN HILL ROAD

18 (a) Funeral director: Lilly and Geiler INC.
(b) Address: 403 S. WOLFE ST.

19 (a) FEB 2 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 31 1944 at 4/05 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1942 to Jan 31 1944.
and that I last saw h[illegible] alive on Jan 31 1944.

Immediate cause of death: Arteriosclerotic Hypertensive C.V. Disease: Cerebral Hemorrhage — Duration: Jan 2/44

Due to: Bronchopneumonia — Duration: Jan 31/44

Due to: Cerebral Hemorrhage — Duration: Jan 31/44

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Ed Schumacher M. D.

Address: 842 S. Eastern Date signed 2-1-44

G 13625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 13625 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Grace Court
(c) Hospital or institution: Curtis Bay
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Grace Court, Curtis Bay
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Hoefler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Matilda Hoefler
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) February 12, 1873

8. AGE: Years	Months	Days	If less than one day
70	11	19	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Andrew Hoefler
13. Birthplace Germany

MOTHER
14. Maiden Name Ida Bresler
15. Birthplace Germany

16 (a) Informant Mrs. Matilda Hoefler
(b) Address 4207 Grace Court, Curtis Bay

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Miller & Amoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

FEB 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1944, at 11.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1944 to Jan 31 1944 and that I last saw him alive on Jan 31 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Levin M. D.
Address 3713 Liberty Hgts Ave Date signed

G 13626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

G 13626 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 43 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Liberty Heights (If rural give location)
(e) Citizen of foreign country? ---- (Yes or No)
If yes, name country ----

3 (a) FULL NAME (Dora W. Cook) Mrs. Royden Cook

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Royden C. Cook
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) July 31, 1879

8. AGE: Years 64 S.T. | Months 6 | Days - | If less than one day: hr. min.

9. Birthplac La Plata, Md. (Town, county, and state)

10. Usual Occupation ----

11. Industry or business ----

FATHER
12. Name F. Hughes Wills
13. Birthplace La Plata, Md.

MOTHER
14. Maiden Name Mary Digges
15. Birthplace La Plata, Md.

16 (a) Informant Royden C. Cook
(b) Address 4409 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address FEB 2 - 1944 05 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1944, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to Hypertensive cardiovascular disease.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed February 1, 1944

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13627 Registered No. 938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 Woodlawn Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 77 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Woodlawn Road (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Mary Florence Rodgers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Patrick Rodgers
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1867

8. AGE: Years	Months	Days	If less than one day
77	0	0	---hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Peter Gill
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Clabby
15. Birthplace Ireland

16 (a) Informant Mrs. Rodney J. Brooks
(b) Address 115 E. Melrose Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Myers and Son
(b) Address 805 N. Calvert Street

19 (a) [illegible] (Date received by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1944, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/44 19.. to 2/2/44 19.., and that I last saw her alive on 2/2/44 19..

Immediate cause of death: Arteriosclerotic Heart disease with acute left sided failure — Duration 6 mos

Due to: arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Frances W. Gluck M. D.
Address 715 Park Ave Date signed 2/3/44

G 13628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13628 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Elkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 W. High Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES P. GRIFFIN

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Carr Griffin
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1886

8. AGE: Years 58 | Months -- | Days 17 | If less than one day hr. min

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Inspector-State Roads

11. Industry or business

FATHER
12. Name Samuel M. Griffin
13. Birthplace Maryland

MOTHER
14. Maiden Name Alethe Jenkins
15. Birthplace Maryland

16 (a) Informant Mrs. Mary Carr Griffin
(b) Address 232 W. High St. Elkton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Ave

18 (a) Funeral director CHAS F. EVANS & SON
(b) Address 118 W. Mt. Royal Ave

19 (a) 1944 (b) Huntington Williams, M.D.
Date filed by Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1944, at 10:30 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Drowning (Probably accidental)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-30-43 at 10:30 A. M.
(b) Where did injury occur? Canton Point St.
(c) Did injury occur at home, on farm, industrial place, in public place? Yes While at work? Unknown
(d) Means of injury drowning

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed 1-31-44

Street age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13629

Monday

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 178a

G 13629
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospl
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town ✓ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll E. Horne ✓

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 212-10-3873

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single ✓
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 46 | Months 0 | Days 22 | If less than one day: hr. min

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Auto. Mechanic
11. Industry or business autos

FATHER
12. Name Thomas O. Horne
13. Birthplace S. Va. Md.

MOTHER
14. Maiden Name S. Virginia Bell
15. Birthplace Md.

16 (a) Informant Naomi F. Horne
(b) Address Randallstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4/44 (month) (day) (year)
(c) Cemetery or crematory Wards Chapel
Location Randallstown Md

18 (a) Funeral director John Oldfield Sons
(b) Address 1960 Eutaw Place

(a) Date received (month) (day) (year) FEB 2 1944
(b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION 26

20. DATE OF DEATH February 2 1944, at 8 A. M

21. I certify that I took charge of the remains described above, held an Inspection & Chemical Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 2nd, 1944 7 10 A. M.
(b) Where did injury occur? 3402 Reisterstown Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled gas from heater

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Feb. 2 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 151

13630 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 13630

CERTIFICATE OF DEATH 107 D13630

1. PLACE OF DEATH Registered No.

CITY OF BALTIMORE: (No. 3016 Auchentoroly Terrace Ward) 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Alice Windsor Buck 3 If U. S. Veteran specify WAR ...

(a) Residence: No. 3016 Auchentoroly Terrace St., ... Ward. ...
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of C. Louis Buck

6. DATE OF BIRTH (month, day, year) May-10-1859

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
84	8	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) Sharpstown (State or country) Wicomico Co., Md.

FATHER

13. NAME Alfred M. Windsor

14. BIRTHPLACE (city or town) Sharpstown (State or country) Wicomico Co., Md.

MOTHER

15. MAIDEN NAME Cecilia Dashiell

16. BIRTHPLACE (city or town) Sharpstown (State or country) Wicomico Co., Md.

17. INFORMANT Mrs. Alice Windsor Buck (self) (Address) 3016 Auchentoroly Terrace.

18. BURIAL, CREMATION, OR REMOVAL Place Sharpstown, Md. Date Feb. 3, 1944

19. UNDERTAKER Stewart & Mowen Company (Address) 108 W. North Ave., Balto., Md.

20. FILED FEB 2 1944, 19... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 1, 1944

22. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1944 to Feb. 1, 1944

I last saw her alive on Jan. 24, 1944. Death is said to have occurred on the date stated above, at 10 p m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	1 Day
Influenza 7 days	

Other contributory causes of importance:

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ...

(Signed) W. J. Boyton M. D.

(Address) 2040 Eutaw Pl

State CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificate.

VS 8

G 13634 G 13634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. [redacted]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. The Hopkins Apt. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Josephine Gertrude Gough Carroll~~ Mrs. Thomas Myer Carroll (~~Gertrude~~ Gertrude Gough)

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife THOMAS M. CARROLL
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 27, 1878

8. AGE: Years 65 | Months 9 mos | Days 6 da. | If less than one day hr. min

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Thomas M. Gough
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary G. Maguire (McGuire)
15. Birthplace Maryland

16 (a) Informant Mrs. T. Gough Lansdowne (sister)
(b) Address 2436 St. Paul Street - City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Homeland Ave. - Balto., Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) Date received by registrar FEB 2 1944 (b) Signature of registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 19 44 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 19 44 to Feb. 2 1944 and that I last saw h[er] alive on Feb. 1 19 44.

Immediate cause of death: Cardiac Failure — Duration

Due to Coronary ~~Occlusion~~ Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. L. Queeney M. D.
Address Union Memorial Hosp. Date signed 2/2/44

G 13632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 13632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & 34th Sts.
(c) Hospital or institution: Cambridge Apts. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cambridge Apts.
(If rural give location)
(e) Citizen of foreign country? -no- (Yes or No)
If yes, name country —

3 (a) FULL NAME Frederic DeWitt Davis

3 (b) If veteran, name war: none
3 (c) Social Security Account No. - no -

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower.
6 (b) Name of husband or wife: Catherine Davis
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 20 1869

8. AGE: Years 74 | Months 10 | Days 13 | If less than one day: hr. min.

9. Birthplace Irvington - N.Y.
(Town, county, and state)

10. Usual Occupation none
11. Industry or business none.

FATHER — 12. Name David Davis
13. Birthplace New York State

MOTHER — 14. Maiden Name Alice M. Henry
15. Birthplace New York State

16 (a) Informant Mrs Samuel Weber Jr. (daughter)
(b) Address Cambridge Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-44 (month) (day) (year)
(c) Cemetery or crematory Dale
Location Ossining - N.Y.

18 (a) Funeral director Steward & Lorman Co.
(b) Address 108 W. 43rd Ave.

19 (a) 1944 (Date received by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1944, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 31 1944, to February 2 1944, and that I last saw h[illegible] alive on Feb. 2 1944.

Immediate cause of death	Duration
Coronary Occlusion	2 hrs
Due to Arteriosclerotic Heart Disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis W. Gluck M. D.
Address 215 Park Ave. Date signed 2/2/44

Remarks: for Williams, [illegible]

Every item of information bearing on cause of death should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 F

G 13633 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution: West Balt Gnl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2745 Huntington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD L. McALLISTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/22/11

8. AGE: Years	Months	Days	If less than one day hr	min
32	0	10		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business Quaker Poultry Co.

FATHER
12. Name Thos. A. McAllister
13. Birthplace Md

MOTHER
14. Maiden Name Mabel Mayer
15. Birthplace Md.

16 (a) Informant Thos A McAllister
(b) Address 2745 Huntington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-44 (month) (day) (year)
(c) Cemetery or crematory
Location Cambridge Md

18 (a) Funeral director Granville Robertson
(b) Address Cambridge Md

19 (a) 1944 (b) (Filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2/44 19 . at 11:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30/44 19 . to 2/2/44 19 .
and that I last saw him alive on 2/2 19 44 .

Immediate cause of death: Hemopericardium — Duration:
Due to Lymphosarcoma (?)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 2/2/44
Major findings of operation: Hemopericardium, Hemothorax, lymphadenopathy
of autopsy: mediastinal, abdominal

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. N. Friedman M.D.
Address WBGH Date signed 2/4/44

G 13634

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13634 Registered No. 46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St.
(c) Hospital or institution: Union Mem. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town ~~Baltimore~~ Timonium, Md.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 8 Northwood Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Raleigh Burroughs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1939

8. AGE: Years	Months	Days	If less than one day
4	11	14	13 hr. min.

9. Birthplace Baltimore, Md. (Town, County, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Raleigh S. Burroughs
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jessie Paxton
15. Birthplace England

16 (a) Informant Mother
(b) Address Timonium, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/44 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director John Bosse' Sons
(b) Address Towson, Md.

FEB 2 1944 (Date filed by registrar) Huntington Williams (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2/44 1944; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24, 1944 to Feb 2, 1944 and that I last saw him alive on Feb 2, 1944.

Immediate cause of death	Duration
Cardio-Respiratory failure	12 days or longer
Due to Malignancy - primary site unknown - Malig	
Due to Small bowel, metas. - liver, peritoneum & mentum.	
Other Conditions assoc. - hydronephrosis	

(Include pregnancy within 3 months of death)

Date of operation 2/2/44

Major findings of operation: Malig. Small bowel & colon - to liver, peritoneum & mentum.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh Bowman M. D.
Address M. Mem Hosp Date signed 2/4/44

13635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

38 E

Registered No. G 13635

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hartford Rd. & Harvey Ave
(c) Hospital or institution:
Sydenham
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 72 S. Monroe (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Myrtle Deane Goulden

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/9/43

8. AGE: Years	Months	Days	If less than one day
	7 mo	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George L. Goulden
13. Birthplace Baltimore

MOTHER
14. Maiden Name Alberta Thompson
15. Birthplace Baltimore

16 (a) Informant George L. Goulden
(b) Address 72 S Monroe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md.

18 (a) Funeral director Haley & Wiltsh
(b) Address 4101 Edmondson Ave.

19 (a) FEB 3 - 1944 (b) Huntington Williams, Registrar
Filed by Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1944, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 19 44 to Feb 2 1944, and that I last saw her alive on Feb 1 19

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia	1 day
Due to	
Other Conditions Varicella (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: ~~pneumonia~~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 2-2-44

13636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G 13636
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address William & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 745 W. Lanvale St. (30) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Warns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Hall Barbara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 13, 1867

8. AGE: Years 76 | Months 9 | Days 18 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Glass Blower

11. Industry or business Retired

FATHER 12. Name Henry

13. Birthplace Marguerite Md.

MOTHER 14. Maiden Name Marguerite

15. Birthplace Md

16 (a) Informant Mrs. Gertrude Gregg

(b) Address 1020 - 19th St. N.W. - Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/44 (month) (day) (year)

(c) Cemetery or crematory Mer Cathedral

Location 4300 Old Frederick Rd

18 (a) Funeral director Harry H. Nuttle

(b) Address 410 Edmondson Ave

FEB 3 - 1944

(Date received by registrar) (b) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 31 1944 at 5:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 21 1944 to 1-31 1944 and that I last saw him alive on 1/31 1944.

Immediate cause of death Carcinoma of prostate gland — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Nuttle Koontz M.D.

Address St. Agnes Hosp. Date signed 1/31/44

13637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 13637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Stelmach

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Laura Stelmach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business Bethlehem, Fairfield

FATHER
12. Name Stephen Stelmach
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Laura Stelmach
(b) Address 2009 S Lombard St.

17 (a) Burial (b) Date thereof Feb. 4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 938 Eastern Ave.

19 (a) FEB 3 - 1944 (Signature) for Williams, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1- 19 44 at 8 25 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Obstruction of Coronary Artery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur: at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 2-1-44

VS 151

13638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13638
Registered No. 119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution:
University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Prince George
(b) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Main St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Elizabeth Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

5 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1944

8. AGE: Years	Months	Days	If less than one day
		22	hr. min.

9. Birthplace Laurel, Md.
(Town, county, and state)

10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name H. Phelps Carr
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha E. Carr
15. Birthplace Md

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3-44 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Laurel Md

18 (a) Funeral director Lloyd Kaiser
(b) Address Laurel Md

FEB 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1944. at 4:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14, 1944. to Feb. 2, 1944. and that I last saw her alive on Feb. 2 1944.

Immediate cause of death	Duration
Pulmonary Edema	8 hours
Due to Cardiac failure	12 hours
Due to Dehydration & Diarrhea	2 days
Other Conditions Premature Birth	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. E. Hoke, M. D.
Address Univ. Hosp. Date signed 2-3-44

G 13639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13639
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 S. Paca St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 424 S. Paca St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ada Webb

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Thomas Webb
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years	Months	Days	If less than one day
About 57			hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Not known
13. Birthplace W. Va.

MOTHER
14. Maiden Name Not known
15. Birthplace W. Va.

16 (a) Informant Mr. Thomas Webb
(b) Address 424 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-3-44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director John A. Grebliauskas Jr
(b) Address 423 S. Paca St.

FEB 2 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1944 at 8. A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1943 to 2-1 1944 and that I last saw h— alive on 2/1 1944

Immediate cause of death Acute Cardiac Failure
Due to Arteriosclerosis Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 1 da.
6 mos.

Major findings:
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph B Loudenslager M.D.
Address 625 W Johnston Sq Date signed 2/3/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

13640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13640
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Kingsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Alberta Brown
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1868
8. AGE: Years 76 | Months | Days | If less than one day: hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert M. Brown
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Elley Howard
15. Birthplace Baltimore Maryland

16 (a) Informant Miss Elley Hall
(b) Address 1818 Eutaw Place, Baltimore, Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md
18 (a) Funeral director H. W. Jenkins & Son Co.
(b) Address McCulloh & Orchard Sts.
FEB 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1944, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1944 to Feb 1 1944, and that I last saw her alive on Feb. 1 1944.

Immediate cause of death: Cardio-Respiratory Failure — Duration
Due to Cerebral Hemorrhage
Due to Hypertensive Cardio-Vascular Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy: ~~Autopsy~~ ~~would~~ ~~not~~ ~~throw~~ ~~any~~ ~~further~~ ~~light~~ ~~on~~ ~~the~~ ~~cause~~ ~~of~~ ~~death~~

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Stephen J. Van Lill III M. D.
Address Union Memorial Hosp. Date signed 2-7-44

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

13641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

Registered No. G 13641

PLEASE WRITE PLAINLY, with pen and ink. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1313 E. Fayette St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1313 E. Fayette St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Simsie D. Gaskins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife Reginald Gaskins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1898

8. AGE: Years	Months	Days	If less than one day
45	9	29	hr. min.

9. Birthplace Orangeburg, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace "

MOTHER

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Pauline Hamilton

(b) Address 1313 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley Ave.

19 (a) Date received by registrar FEB 3 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 19XX, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15, 19XX to Jan. 31, 19XX, and that I last saw h alive on Jan. 30, 19XX.

Immediate cause of death Cancer of Uterus — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Mark Adams, M.D.

Address 312 E 23rd St Date signed 2-2-XX

13642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G 13642

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County Cecil
(c) City or town Cecilton City (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs. Ida L. Nichols

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	W

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29-1889

8. AGE: Years	Months	Days	If less than one day
54	9	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Home Work
11. Industry or business

FATHER
12. Name Nathaniel Melvin
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Stitchberry
15. Birthplace Md

16 (a) Informant R. A. Nichols
(b) Address George St. Chesapeake City

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-4-44 (month) (day) (year)
(c) Cemetery or crematory North East
Location North East Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 Osborne St.

19 (a) (Date rec'd by Registrar) 1944 (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2 1944, at 1.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1944, to 2-2 1944, and that I last saw her alive on 2-2 1944.

Immediate cause of death	Duration
Intestinal obstruction	
Due to abd. peritonitis	
Due to intestinal resection	
Other Conditions Ca of cecum?	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Raynor M. D.
Address Md. Gen. Hosp. Date signed 2/2/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

13643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13643
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Address 3510 Grantley Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Grantley Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA M. NORDENHOLZ

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Ernest E. Nordenholz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1876

8. AGE: Years	Months	Days	If less than one day
67	3	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Arnold E. Hillegeist
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Bishop
15. Birthplace Balto.

16 (a) Informant Mrs. Edna Kemmer
(b) Address 3510 Grantley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 8 1944 (Date rec'd by registrar) (b) Filing for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1944 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1943 to Feb. 2 1944.
and that I last saw h alive on Feb. 1, 1944.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to (Arteriosclerosis)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney L. Levy M. D.
Address 2322 Eastern Pkwy Date signed 2/2/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 Montpelier St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Houck

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ W

6 (b) Name of ~~husband or~~ wife Sarah R. Houck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1877

8. AGE: Years 66 | Months 6 | Days 5 | If less than one day: hr min

9. Birthplace Philadelphia Penn. (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Peters & Worthington

FATHER
12. Name Joseph C. Houck
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Knight
15. Birthplace ~~England~~ Penna

16 (a) Informant Harold E. Pryor
(b) Address 235 Robb St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 835 St. Paul St

19 (d) FEB 3 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1944, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1944 to Feb. 1 1944, and that I last saw him alive on Feb. 1 1944

Immediate cause of death Cardio-respiratory failure — Duration

Due to Cerebral embolism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J P Guyther M.D.

Address Mercy Hosp Date signed 2/4/44

VS 150

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly, WITH UNFADING INK.

G 13645
JL - 84462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13R

Registered No. G 13645

Every item of information should be carefully checked, with UNFADING INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Smith

3 (b) If veteran, name war: NV
3 (c) Social Security Account No.: NHB

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1868

8. AGE: Years	Months	Days	If less than one day
75	3	[illegible]	hr. min.

9. Birthplace Bavaria - Germany (Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name John Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Bickel
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/3/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Wilkens Bros Inc
(b) Address 127 St. Paul St

19 (a) FEB 3 - 1944 (Date rec'd by registrar) (b) Huntington Hollins Mortuary

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1943 to 2/1 1944, and that I last saw h alive on 2/1 1944.

Immediate cause of death
Pulmonary TBC

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Malt
Address B.C.H. Date signed 2/1/44 M. D.

B 13646 T.N 85707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 13646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Pine St (If rural give location)
(e) Citizen of foreign country? [redacted] (Yes or No)
If yes, name country

3 (a) FULL NAME: Fred Hagedorn

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 30, 1874

8. AGE: Years: 69 Months: 2 Days: 2 If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: Henry Hagedorn
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline Woolford
15. Birthplace: Germany

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year): 2/5/44

(c) Cemetery: Maryland Park
Location: Parkville Md.

18 (a) Funeral director: Gilliam Bros Inc
(b) Address: 1[illegible] St. Paul St

19 (a) FEB 3 - 1944 (Date rec'd by registrar) (b) Huntington Gilliam M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/2 1944 at 2:30 P.M.

21. I certify that: death occurred on the date above stated; that I attended deceased from 12/1 1943 to 2/2 1944 and that I last saw him alive on 2/2 1944.

Immediate cause of death: Coronary Arteriosclerosis — Duration: 3-4 d.

Due to

Due to

Other Conditions: A.S.C.V.D.; gen. arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

Date of autopsy: Card: hypertrophy; nephrosclerosis; kidney [illegible]; cirrhosis of liver

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E. L. Seagman M. D.

Address: BCH Date signed 2/3/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 13647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 E. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Bierau

3 (b) If veteran, name war	3 (c) Social Security Account No.
NV	None

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Margaretta Bierau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22nd 1867

8. AGE: Years	Months	Days	If less than one day
76	2	9	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Retired Sales Manager
11. Industry or business Nat'l Biscuit Co.

FATHER
12. Name Conrad Bierau
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Henry V. Bierau
(b) Address 340 Midland Ave

17 (a) Entombment (b) Date thereof 2-5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ Lorraine Mausoleum
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) FEB 3 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1st 1944, at 10:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24/43 to 2/1/44, and that I last saw him alive on 2/1/44.

Immediate cause of death Coronary thrombosis — Duration 2 hrs.

Due to Coronary sclerosis

Due to General arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon A. Barden
Address 1517 E. North Ave Date signed 2/3/44

Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13648

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 83a

G 13648 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 N. Luzerne Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Florence B Webster (Florence B. Webster)

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-12-2055

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George R. Webster

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 5th, 1871

8. AGE: Years	Months	Days	If less than one day
72	5	27	######## hr. ######## min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lennox T. Bramble
13. Birthplace Missouri

MOTHER
14. Maiden Name Anna Slacum
15. Birthplace Maryland

16 (a) Informant Mr. Joseph Meyers Webster
(b) Address 1306 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Feb. 4th, 1944 (month) (day) (year)
(c) Cemetery or crematory Forlands Memorial Park
Location Taylor Avenue Balto, Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

FEB 3 - 1944 (Date rec'd by registrar)

19 (a) ____ **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1-44 19____, at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1944 to 2-1- 1944, and that I last saw her alive on 2-1- 1944.

Immediate cause of death Cardiac Hemorrhage — **Duration** 8 days

Due to Arterio-sclerosis. — ?

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. Mydelland M. D.
Address 1913 Light St **Date signed** 2-1-44.

VS 3

3849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 61

G 13649
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Pelham Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary Fink
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Frank A. Fink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mr. 20 - 1860

8. AGE: Years	Months	Days	If less than one day
83	3 2	2 12	hr. min.

9. Birthplace Emmittsburg Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Braun
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Conga
15. Birthplace Germany

16 (a) Informant Clara M. Fink
(b) Address 2222 Pelham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Geo M. Fink & Son
(b) Address 861 N Wolfe St

19 (a) FEB 3 - 1944 (Date of data received) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1944 at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944 to Feb 2 1944 and that I last saw her alive on Feb 1 1944.

Immediate cause of death Congestive heart failure — Duration
Due to Arteriosclerosis
Due to Pneumonia (Left Lung)
Other Conditions Diabetes mellitus
Amputation of R+ leg (mid thigh)
(Include pregnancy within 3 months of death)
Date of operation June 26, 1944
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph's Hospital Date signed 2-2-44

G 13650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13650
Registered No.

50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2938 Clifton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

15 T

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2938 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Hinds Reede

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Emmett P. Reede
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 26 1874

8. AGE: Years	Months	Days	If less than one day
69	7	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Charles H. Hinds
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Rachel Sumwalt
15. Birthplace Baltimore Md

16 (a) Informant Emmett P. Reede
(b) Address 2938 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry A. Annacker
(b) Address 4204 Ridgewood Ave

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

FEB 9 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1944, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to 2/2 1944, and that I last saw her alive on 2/1 1944.

Immediate cause of death Carcinoma of stomach-mary gland

Duration 1 yr 1 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 3902 Greenmount Date signed 2/3/44

13651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 13651
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Lennox St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney N. Wolman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 24, 1892

8. AGE: Years 51 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Asst. Engineer. Signals

11. Industry or business Repair Shop, U.S.A.

FATHER
12. Name Solomon Wolman
13. Birthplace Poland

MOTHER
14. Maiden Name Esther L. Schroeder,
15. Birthplace New York.

16 (a) Informant Mr. Paul C. Wolman,
(b) Address 2701 Lavina Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/44. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director David Sonnenstein & Son
(b) Address 1902 Eutaw Place

19 FEB 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1944 to 2-2 1944, and that I last saw him alive on 2-2 1944

Immediate cause of death: Cerebral vascular accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 2-2-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myron S. Cornet M. D.
Address Sinai Hosp. Date signed 2-2-44

VS 150

13652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13652

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4501 Curtis avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Montpelier St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Henry~~ HENRY W. Nicklas

3 (b) If veteran, name war none

3 (c) Social Security Account No. 215-07-0256

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Emma Nicklas

6 (c) If alive, give age 1896

7. Birth date of deceased (mo., day, yr.) January 9, ~~1875~~

8. AGE: ~~Years~~ 68 | Months 0 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name William L. Nicklas
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Anna E. Roth
15. Birthplace Baltimore, Md

16 (a) Informant Emma Nicklas
(b) Address 3456 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director Howard N. Bayliss Jr.
(b) Address 4914 Belair Road

19 (a) FEB 3 1944 Huntington Williams (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1944, at 10 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Marked coronary arteriosclerosis
Infarct of myocardium

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. (Medical Examiner)
Date signed Feb. 2 1944

VS 151

(over)

13653 G 13653

448547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 157H

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 253 S. Regester (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CARMIN RUNK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-44

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clayton RUNK
13. Birthplace Md

MOTHER
14. Maiden Name ~~Mamie~~ Kolb
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Ave

18 (a) Funeral director Howard M. Bligh Jr
(b) Address 4914 Belair Road

FEB 3 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1944 at 2.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 28 1944 to Feb 3 1944 and that I last saw HIM alive on Feb 3 1944.

Immediate cause of death: Respiratory failure — Duration
Due to: Urinary obstruction
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rosen Kaye
Address JHH Date signed 2/3/44

VS 150

Notice: Please write the causes of death clearly and legibly. The space for "Duration" is important. Physicians: please write the causes of death clearly and legibly. The space for "Duration" is important. Please write the causes of death clearly and legibly. The space for "Duration" is important.

13654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121C

Registered No. C 13654

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3319 W. Gilmore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city limits write RURAL and give town)
(d) Street No. 331 W. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Campbell Cann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	divorced

6 (b) Name of husband or wife Bill Cann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1884

8. AGE: Years	Months	Days	If less than one day
59	7		hr. min.

9. Birthplace Lynchburg Va. (Town, county and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name William Campbell
13. Birthplace Lynchburg Va

MOTHER 14. Maiden Name Ann Turner
15. Birthplace Va

16 (a) Informant Katie Jones Preston
(b) Address 1012-16th St Lynchburg Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3 1944 (month) (day) (year)
(c) Cemetery or crematory Lynchburg Va
Location

18 (a) Funeral director Miss Katie R. Williams
(b) Address 222 E. Edmondson St. Huntington West Va.

FEB 3 - 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1944 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1944 to Jan 31 1944 and that I last saw her alive on Jan 29 1944

Immediate cause of death Valvular Heart Disease — Duration 1 month

Due to

Due to

Other Conditions nephritis — Duration ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard

Address 1431 N Franklin Date signed M 2/2/44 D

G 13655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13655 Registered No. 1312a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hr
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 W. Mulberry (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herman J. Weisner Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Lillian Weisner.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14 - 1884.

8. AGE: Years	Months	Days	If less than one day
59	3	18	hr. — min

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER 12. Name ~~Herman Weisner~~ Adolph Weisner
13. Birthplace Germany

MOTHER 14. Maiden Name Minnie Stephon.
15. Birthplace Germany

16 (a) Informant Mrs. Lillian M. Weisner.
(b) Address 1817 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5-44. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) [illegible] Huntington Williams, M.D.
(Date received by registrar) Registrar

B 3 VS 144. 3-1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st 1944, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1944, to Feb. 1st 1944, and that I last saw him alive on Feb 1st 1944

Immediate cause of death	Duration
Cerebro-vascular accident	
Due to Kidney disease & uremia	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Strobel M. D.
Address Univ. Hospital Date signed

Approved: Robert Lee Graham M.D. Feb. 3 1944

Persons required by law to report deaths are specially important. Physicians: please write the causes of death clearly and legibly.

G 13656

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13656
Registered No. 171a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Smith Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write "R.F.D." and give town)
(d) Street No. 601 Patapsco Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaias Gonzales

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 43 | Months | Days | If less than one day: hr min

9. Birthplace (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER: 12. Name
13. Birthplace

MOTHER: 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-4-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. C. Co.

18 (a) Funeral director Robert F. Brooks
(b) Address 338 Hollins St.

19 (a) (Date received by Registrar) (b) Livingston Williams, M.D. Registrar

FEB 3 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1944, at 9:50 P.M.

21. I certify that I took charge of the remains described above, held an Inquestion thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:
(a) Date of injury January 23, 1944 9:20 P.M.
(b) Where did injury occur? East Lanvale & Charles
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? No
(d) Means of injury Struck by Streetcar

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed January 24, 1944

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13657

Registered No. 55E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Barrington Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERTRAM KAMBER

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1915

8. AGE: Years	Months	Days	If less than one day
29	0	6	hr min

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Ph M 2/c
11. Industry or business Maritime Service

FATHER
12. Name Abraham Kamber
13. Birthplace Russia

MOTHER
14. Maiden Name Sadie Goldstone
15. Birthplace New York City

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4/44 (month) (day) (year)
(c) Cemetery or crematory Hebrews Herring Run
Location Bowley Land

18 (a) Funeral director Sol Levin & Bros
(b) Address 1124-26 W. North ave

19 (a) Filed by registrar 3-1944 (b) Registrar Huntington Williams, M.D.

MS-50656

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH February 2, 1944, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26, 1944, to Feb. 2, 1944, and that I last saw him alive on Feb. 2, 1944.

Immediate cause of death Generalized metastatic lympho-epithelioma

Duration Approx. Sept. 1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None done
Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Archer, M.D.
Address Baltimore, Md. Date signed 2/3/44

G 13658

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13658 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 Dryden Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Dryden Drive (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Susan T. Wilkinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George W. Wilkinson
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1863

8. AGE: Years	Months	Days	If less than one day
80	1	7	--- hr. -- min.

9. Birthplace Covington, West Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Patrick Winters
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McFarland
15. Birthplace Ireland

16 (a) Informant George W. Wilkinson Jr.
(b) Address 709 Dryden Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

FEB 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1944, at 7:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1939 to Feb 1 1944. and that I last saw h alive on Feb 1 1944.

Immediate cause of death	Duration
Coronary Embolism	1 hr.
Due to Myocarditis	5 yrs.
Due to Arterio-sclerosis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Elbrace M. D.
Address 603 Bird Ave Date signed 2-2-44

URBAN

G 13659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13659

Registered No. 131a

PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 6508 Old Harford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6508 Old Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calogero George De Basquale

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Carmella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1891

8. AGE: Years	Months	Days	If less than one day
53 52	-	27	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Shoe Repairer
11. Industry or business

FATHER
12. Name Joseph De Basquale
13. Birthplace Italy

MOTHER
14. Maiden Name Michelfine Salerno
15. Birthplace Italy

16 (a) Informant Carmella De Basquale
(b) Address 6508 Old Harford Rd

17 (a) Burial (b) Date thereof 2 - 4 4
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J Ruck
(b) Address 5305 Harford Road

19 (a) FEB 3 - 1944 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1938 to Feb - 2 1944 and that I last saw h alive on Feb 2 1944.

Immediate cause of death Cerebral hemorrhage — Duration 26 hrs
Due to Hypertensive cardio vascular Renal disease — 6 yrs
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature S. A Alessi M. D.
Address 6217 Harford Rd Date signed 2-3-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

13660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. S 13660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 2days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Granby Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Ford

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1944

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Elmo Murray
13. Birthplace Louisiana

MOTHER
14. Maiden Name Eunice Ford
15. Birthplace Kentucky

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location JOHNS HOPKINS HOSPITAL SURGICAL FEB 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 3 1944 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1944, at 3.55PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 1944, to Jan. 27 1944, and that I last saw him alive on Jan. 27 1944.

Immediate cause of death Prematurity — Duration

Due to Atelectasis

Due to (over)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation to be Atelectasis

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stephens, Jr. M.D.
Address Johns Hopkins Hospital Date signed 1-28-44

0702

G 13661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 13661 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 W. Camden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Murray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 3 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1944, at 11 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Jan 9 1944

070

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13662 M. C. Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13662 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Washington Blvd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHNS HOPKINS MEDICAL SCHOOL FEB 3 1944 Commissioner of Health

18 (a) Funeral director

(b) Address 4044

19 (a) FEB 3 1944 (Date rec'd by registrar) (b) [illegible] Registrar

0700

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1944, at 11:53 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1944 to 1-12 1944 and that I last saw him alive on 1-12 1944.

Immediate cause of death: Lobar Pneumonia — Duration 10 dys.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. Maydwell M. D.

Address 1213 Light St. Date signed 1-12-44

correct age in especially important

G 13663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1944

Registered No. G 13663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 E. 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawson S. Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Betty Jeanette Mullin Perkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 30 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace West Va Va
(Town, county and state)

10. Usual Occupation Master Carpenter

11. Industry or business

FATHER
12. Name Mason Perkins
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Hunsinger
15. Birthplace Penn

16 (a) Informant James Perkins
(b) Address 918 E Biddle St

17 (a) Burial (b) Date thereof 2/4/44
(month) (day) (year)
(c) Cemetery or crematory outskirts of Boston, Md
Location

18 (a) Funeral director John E Mahan
(b) Address 3000 E Balto St

19 (a) FEB 3 - 1944 (Date rec'd by Registrar) (b) Hunting Town Williams, M.F. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1944, at 9:45 A. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-3-44 at 7 10 P.M. 2:16
(b) Where did injury occur? Belt line Railroad
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury struck by piece of timber

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 2-3-44

VS 181

G 13664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

2136 G 13664 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 N. Ellwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Pijanowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife 1882
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wawrzyniec Pijanowski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Mrs. Anna Pijanowski
(b) Address 308 N. Ellwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary cem
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 401 S. Chester Street

19 (a) 2-1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1 1944, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1944, to 2/1 1944, and that I last saw him alive on 2/1 1944.

Immediate cause of death Cardiac failure — Duration

Due to Ac. myocardial infarction

Due to Arteriosclerotic h. dis.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Ac myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Aikman M. D.
Address Date signed

VS 180

Leonard Aikman

13665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Myrtle ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Myrtle ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 2 | Days | If less than one day: hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL FEB 3 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) FEB 3 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29- 1944, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Bronchopneumonia

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.

Date signed 1-29-44

0703

13666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/15

Registered No. 13666

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore, Md.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 70 Albemarle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 3 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1944, at 8:30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH miliary tuberculosis; tuberculous peritonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 1-15-44

0.04

13667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 13667

1161c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 26-4
(d) Length of stay on hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Courtland Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 3 1944 (Date rec'd by Registrar) (b) Huntingtown Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1944 at 1 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema

Hemorrhage from torn umbilical cord.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 23 1944 A.M.
(b) Where did injury occur? Miami Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Hotel While at work? No
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner
Date signed Jan 24 1944

0136

13668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13668
Registered No.

1600a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 Dunham St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Dunham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Carson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL

18 (a) Funeral director
(b) Address

19 (a) FEB 3 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

0705

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1944, at 11:00 A M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhage

Due to birth injury

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grate M.D.
Medical Examiner.
Date signed January 30, 1944

G 13669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 13669
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lexington Sts
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [illegible]
(c) City or town Dundalk - Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Bay Brier Rd
(If rural give location)
(e) Citizen of foreign country? ___ (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1943

8. AGE: Years	Months	Days	If less than one day
	1	4	38 hr min

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Paul Freeman
13. Birthplace N.C.

MOTHER
14. Maiden Name Dorothy Hobson
15. Birthplace N.C.

16 (a) Informant Mrs. Paul Freeman
(b) Address 3107 Bay Brier Rd - Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-44 (month) (day) (year)

(c) Cemetery or crematory Lt Peters
Location Balto Md

18 (a) Funeral director Guy C Fuller
(b) Address Fullers Fayette

18 Feb 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31, 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3, 1944, to Jan 31, 1944, and that I last saw him alive on Jan 31, 1944.

Immediate cause of death	Duration
Resp. Failure	
Due to Dehydration,	
Due to Acidosis, Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Timmons M. D.
Address Mercy Hosp Date signed 2/1/44

correct age is especially important. Physicians, please

VS 150 -

G 13670

G 13670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution Franklin Sq. Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 45 N Fremont (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Hugh Mc Conville

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Eva M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1884

8. AGE: Years	Months	Days	If less than one day
59	2	3	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business

FATHER
12. Name Hugh Mc Conville
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McCann
15. Birthplace Ireland

16 (a) Informant Mrs Eva M Conville
(b) Address 45 N Fremont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Lyne A Farley
(b) Address Fulton & Fayette

19 (a) 1944 Huntington Md (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7-44 19 , at 7:20 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27-44 19 , to 2-7-44 19 , and that I last saw h alive on 2-7-44 19 .

Immediate cause of death — Duration

Subarachnoid Hemmorhage

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Leahy M. D.
Address Frank. Sq. Hospt Date signed 2/3/44

VS 3

G 13671

T. N 86218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G 13671

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 W. Coldspring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Kean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29 1879

8. AGE: Years	Months	Days	If less than one day
64	9	3	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER	12. Name	?	James May Kean
	13. Birthplace	?	Ireland
MOTHER	14. Maiden Name	?	Sarah Levering
	15. Birthplace	?	Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 2-7-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location Baltimore Md

18 (a) Funeral director Jorge A Fahey
(b) Address Fulton & Fayette

19 (a) Filed (Date received by registrar) (b) Jos Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1, 1944 at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1944 to Feb 1 1944 and that I last saw h. alive on Feb 21 1944.

Immediate cause of death
Carcinoma of uterus with metastases

Duration 7?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. Davenport M. D.
Address Balto City Hosp Date signed Feb 7 1944

13672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 13a

G 13672 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Woodyear St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Woodyear St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanore Burrell

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife Addison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/25/1884

8. AGE: Years	Months	Days	If less than one day
59	3	7	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Geo. Washington
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Smith
15. Birthplace Va

16 (a) Informant Addison Burrell
(b) Address 1117 Woodyear St

17 (a) Burial (b) Date thereof 2/6/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. B. Kilson
(b) Address 1303 Pressman

19 (a) Date received by registrar FEB 4 1944 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1944 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1943 to July 2 1944.
and that I last saw h alive on July 2 1944.

Immediate cause of death

Cardiac Renal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3
Yrs
1 Da
V

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Halsted
Address 1 W Pre Ave Date signed 2/3/44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G 13673 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2710 Southern Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Southern Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? No years

3 (a) FULL NAME AMELIA WILHELMINA STEHLING

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. Stehling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 24, 1838

8. AGE: Years 77 | Months 10 | Days 9 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Louis Warnken
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Caroline Wieland
15. Birthplace: Germany

16 (a) Informant: Mrs. Geo. Schmalbach
(b) Address: 2710 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: North Ave. & Broadway

FEB 4 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 2 1944 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Feb. 2 1944 and that I last saw her alive on 2-1 1944

Immediate cause of death: Coronary Myocarditis — Duration: 2 Months
Due to: Arterial Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: C. W. Peake M. D.
Address: 4508 Hazel Rd Date signed 2-2-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1844

G 13674
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 S. Decker Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN PURCELL

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 214-18-5834

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Annie W. Purcell

6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.) April 13, 1837

8. AGE: Years 76 | Months 9 | Days 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Utility man

11. Industry or business: Brewery

FATHER
12. Name: John Purcell
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Margaret Hoagers
15. Birthplace: Ireland

16 (a) Informant: Mrs. Annie W. Purcell
(b) Address: 812 S. Decker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Baltimore, Md.
HENRY SANDER & SONS, INC.

18 (a) Funeral director
(b) Address: North Ave. & Broadway

FEB 4 1944 (b) Huntington Williams, M.D.
(Date Rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 19 44, at 11:50 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular

Due to Fracture of left femur

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-9-44 at 10:25 P. M.
(b) Where did injury occur? 1100 S. Ellwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Slipped and fell on the street.

23. Signature H. L. Wallenmeyer, M.D.
Medical Examiner.
Date signed 2-3-44.

G 13675

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 13675 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Gannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Murphy
15. Birthplace Ireland

16 (a) Informant Sister Superior Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wuchfeld
(b) Address 2944 Guilford Ave.

FEB 4 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1944, at 11.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1- 1944, to Feb 2- 1944, and that I last saw him alive on Feb 1- 1944.

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic Myocarditis	1 yr.
Due to	
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Bill Hall M. D.
Address 1631 E. North Ave Date signed 2/3/44

13676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 13676 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 N Calhoun St.
(c) Hospital or institution: Franklin Square Hospital 29-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days 40 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore {Hunting Ridge} (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Winans Way. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Robert Otto Eichhorn (Otto Robert Eichhorn)

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife Emma L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1880

8. AGE: Years	Months	Days	If less than one day
63	7	22	hr. min.

9. Birthplace St. Louis, Mo. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Von Hiene Coal Co.

FATHER
12. Name Robert Eichhorn
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Wolf
15. Birthplace Germany

16 (a) Informant Miss Dorothy Eichhorn
(b) Address 715 Winans Way - 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. ~~Hunting Ridge Cem.~~
Location Balto. Md. ~~Pikesville, Md.~~

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1944, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Feb 1 1944, and that I last saw ~~him~~ alive on 2/1 1944.

Immediate cause of death: Carcinoma sigmoid colon with perforation — Duration: Bleeding 2 months
Due to Peritonitis — 6 days
Due to
Other Conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations same
Of autopsy same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luella Leitz
Address 1000 Madison St. Date signed 2/1/44 M.D.

13677 — G 13677

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

S.N 85707 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Pine St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Geraldine Hopkins (Sample)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1920

8. AGE: Years	Months	Days	If less than one day
23	7	7 5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Hokins
13. Birthplace Washington D. C

MOTHER
14. Maiden Name Julia Sample
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 FEB 4 1944 (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1 1944, at 9.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1943 to 2/1 1944.
and that I last saw h[illegible] alive on 2/1 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mabe
Address B. P. H. Date signed 2/3/44

G 13678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 526

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 E Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie McIntyre
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-16-4720

4. Sex: female
5. Color or race: black
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-26-02
8. AGE: Years 41 Months 3 Days 4 If less than one day hr. min.
9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Canner
11. Industry or business

MOTHER / FATHER
12. Name William McIntyre
13. Birthplace N.C
14. Maiden Name Laura McKay
15. Birthplace N.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-44 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Arlington Md.

18 (a) Funeral director Byron & Marie Wright
(b) Address 721 Biddle St.

19 FEB 4 1944 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1944 at 6 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1944 to Jan 30 1944. and that I last saw her alive on Jan. 30 1944

Immediate cause of death Uremia. — Duration 6 months
Pyelonephritis chronic bilateral
Due to Hydronephrosis bilateral Hydroureter — 6 months
Due to Ureteroo sigmoidostomy bilateral
Other Conditions Intractable cystitis — 3 yrs
(Include pregnancy within 3 months of death)
Date of operation August 1943
Major findings of operation: Acute Cystitis ? Carcinoma bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David B. Cheek M. D.
Address Johns Hopkins Hospital Date signed 1-30-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

M. D. P. 1268-9

13679

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 13679

CERTIFICATE OF DEATH

159

1. PLACE OF DEATH 3480 Childs Court

Registered No. .....

CITY OF BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Baby Boy Tanchestone

(a) Residence: No. 3480 Childs St., 25-6 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: wh.

5. Single, Married, Widowed, or Divorced (write the word): Premature infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Jan 28, 1944

7. AGE: Years ½ hr. | Months | Days | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) ..... | 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) .....

FATHER

13. NAME Baron H. Tanchestone

14. BIRTHPLACE (city or town) (State or country) Danville, Va Va

MOTHER

15. MAIDEN NAME Lottie B. Vaughn

16. BIRTHPLACE (city or town) (State or country) Va.

17. INFORMANT .....

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place JOHN HOPKINS MEDICAL SCHOOL Date 2 1944 19

19. UNDERTAKER Commissioner of Health

(Address)

20. Filed FEB 4 1944 19 Huntington Williams M.D. Registrar.

OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan. 28, 1944

22. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1944 to ..... 19 ....

I last saw him alive on Jan 28, 1944 Death is said to have occurred on the date stated above, at 10½ a.m.

The principal cause of death and related causes of importance were as follows:

Prematurity

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Samuel Rubin M. D.

(Address) 20 Biopsy Clinic

0707

G 13680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

Registered No. G 13680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SYDENHAM HOSPITAL 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) / da -
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 E. FORT ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLARD, Clarence Allen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1, 1938

8. AGE: Years	Months	Days	If less than one day
5	11	1	hr. min.

9. Birthplace Rupert, West Virginia (Town, county, and state)
10. Usual Occupation child -
11. Industry or business

FATHER
12. Name James Luther Willard.
13. Birthplace Galena, KANSAS

MOTHER
14. Maiden Name DORA Scaggs
15. Birthplace Tadie, W. VA.

16 (a) Informant hospital records -
(b) Address

17 (a) S. (Burial, cremation, or removal) (b) Date thereof 2-5-44 (month) (day) (year)
(c) Cemetery or crematory East Rainelle
Location East Rainelle W. Va.

18 (a) Funeral director Jos L. K. Cuely
(b) Address 120 E. Fayette.

FEB 4 - 1944 (Date rec'd by registrar)
(b) Huntington, Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1944, at 2 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 2 1944 and that I last saw him alive on Feb 2 1944.

Immediate cause of death	Duration
respiratory failure	
Due to	
diphtheria	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 2-3-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13681

448706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13681
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 E Jefferson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert A. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-29

8. AGE: Years	Months	Days	If less than one day
15	-	26	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Angus Smith
13. Birthplace Md

MOTHER
14. Maiden Name Evelyn Keely
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) FEB 4 1944 (Date rec'd by Registrar) (b) Huntington Nottingham, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1944, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 2 1944, and that I last saw him alive on Feb 2 1944.

Immediate cause of death

Due to Meningococcal meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Bunningham M.D.
Address JHH Date signed 2-2

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/93D

Registered No. G 13682

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 S. Curley St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 S. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Conrad G. Thelen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 12/26/1884

8. AGE: Years 59 | Months 1 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name William Thelen
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Anna Nowak
(b) Address 904 S. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

FEB 4 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1944 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1943 to Feb 2 1944 and that I last saw him alive on Jan 31 1944.

Immediate cause of death: Chr. Myocarditis — Duration: 1

Due to: Chr. arterio-sclerosis — Duration: 7

Due to: — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Davidov M. D.
Address 3218 Eastern Ave Date signed 2-3-44

13683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13683

Registered No. 119a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Kenwood & Madison
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 S. Kenwood Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Caroline Aldrige

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	4		hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Loreng Aldrige
13. Birthplace Balto.

MOTHER
14. Maiden Name Eleanor Reno
15. Birthplace Balto.

16 (a) Informant Reno Aldrige.
(b) Address 826 S Kehwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Annapolis Road

18 (a) Funeral director John J. Tucker
(b) Address 2822 Hudson St.

19 (a) FEB 4 1944 (Registered by Registrar) Huntington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1944, at 6:42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Diarrhea - infantile (cause antedum) — Duration

Due to Patient died a few minute following admission

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Herman Williams M. D.
Address Md. Gen. Hosp. Date signed Feb. 2, 1944

13684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13684
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Elmwood Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine MURDEN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William Murden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1891

8. AGE: Years	Months	Days	If less than one day
52	2	6	5 hr. 20 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Charles Lange
13. Birthplace Germany
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant William B. Murden
(b) Address 702 Elmwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 5 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 2401 Belair Rd.

19 (a) (Date received) FEB 4 1944 (b) Registrar Huntington Williams (Registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1944, at 5:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18 1943, to Feb. 3 1944, and that I last saw her alive on Feb. 3 1944.

Immediate cause of death Cardio-Resp. Failure — Duration

Due to Hypertensive Cardio-Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy Cardiac Hypertrophy & Dilatation of Left Ventricle; Chronic Glomerulonephritis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Hornbrook, M. D.
Address Mercy Hospital Date signed 2/3/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13685
No. 38090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 13685
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs 5 mos 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 12
(d) Street No. No home (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Elizabeth Brownley Knoop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1870

8. AGE: Years 73 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hiram Brownley (d)
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Zevneck (d)
15. Birthplace Europe

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/44 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Frederick Rd

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 N. Broadway

19 FEB 4 1944 Huntington Ave. Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1944, at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 1/30 1944, and that I last saw MA alive on 1/30 1944.

Immediate cause of death: Bronchopneumonia — Duration 5 d.

Due to

Due to

Other Conditions A.S. C.V.D.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Leigmon M. D.

Address BCH Date signed 2/2

VS 180

G 13686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 13686

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 Southern Ave
(c) If hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Southern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Frana-Franz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31st 1885

8. AGE: Years 58 Months 5 Days 2 If less than one day hr. min.

9. Birthplace Md
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry Minnick
13. Birthplace Md

MOTHER
14. Maiden Name Laura Martin
15. Birthplace Md

16 (a) Informant Mrs Irene Monfe
(b) Address 2702 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5th 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo F. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Feb 4 1944 Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2nd 1944, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1942, to Jan 2 1944, and that I last saw h[illegible] alive on Jan 2, 1944.

Immediate cause of death Acute cardiac dilatation — Duration 6 hrs.

Due to Carcinoma Tosis

Due to

Other Conditions Carcinoma Primary of Breast - Ulcerating

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. V. Hayward

Address 114 E Eager St Date signed 2/3 '44 M.D.

13687

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

166

Registered No. C 13687

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Bethel Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1923

8. AGE: Years	Months	Days	If less than one day
20	10	20	hr. min.

9. Birthplace Prince Edward, Va (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John D. Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Gertrude Epps
15. Birthplace Va

16 (a) Informant McKinley Johnson
(b) Address 506 N. Bethel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory
Location Burkville, Va.

18 (a) Funeral director Ebaugh, Wilson
(b) Address 600 Eastern Ave
(c) Registrar Huntington Williams & Co

FEB 4 - 1944
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1944, at 4:10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet Wounds of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at 11:30 P. M.
(b) Where did injury occur? Tevera - 1300 block Greenmount Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed 2-3-44

13688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G 13688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville
(c) Hospital or institution: St. Agnes Hosp 75
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Lauakos Giavaris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary GIAVARIS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1900

8. AGE: Years	Months	Days	If less than one day
43	10	10/17	hr. min.

9. Birthplace Asia Minor (Town, county, and state)
10. Usual Occupation Restaurant Owner
11. Industry or business

FATHER
12. Name George Giavaris
13. Birthplace Turkey

MOTHER
14. Maiden Name Constance Thomas
15. Birthplace Turkey

16 (a) Informant Mary Giavaris
(b) Address 622 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/43 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md

18 (a) Funeral director Edw. J. Mac Gabb
(b) Address Frederick & Wade Catonsville

19 FEB 4 - 1943 (b) Registrar
(Date received by local registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1943 to 2-2 1943; that I last saw h/M alive on 2-2 1943

Immediate cause of death Pulmonary embolism — Duration

Due to operation - nephrectomy

Due to Tumor - malignant - left kidney

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/29/43

Major findings of operation: Hypernephroma (left kidney)

of autopsy:

PHYSICIAN Underline the cause to which it should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Kaffuggi - Asst M. D.
Address St. Agnes Hosp Date signed 2/2/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 652 Dover
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 652 Dover (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chas Edw Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1940

8. AGE: Years 3 | Months 9 8 | Days 10 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Loaring Walker

13. Birthplace Asheville N.C

MOTHER 14. Maiden Name Rose Young

15. Birthplace Anne Arundel Co Md

16 (a) Informant Rosa Walker

(b) Address 652 Dover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 5, 1944 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary

Location Anne Arundel County

18 (a) Funeral director Joseph A. Shipley

(b) Address 401 North Mount St

FEB 4 – 1944 (Date rec'd by Registrar) Huntington Mills

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2, 1944 at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21/ 1944 to 2/2/ 1944 and that I last saw him alive on 2/2/ 1944

Immediate cause of death

Duration

Bronchopneumonia 2 days

Due to Measles

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Howell M. D.

Address 601 N Carrollton Ave Date signed 2/3/44

VS 180

13690 TLUMOK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

Registered No. G 13690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 S. Durham St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 S. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Tlumok Tomasz (Talewicz)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George Tlumok

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1886

8. AGE: Years	Months	Days	If less than one day
58	—	—	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at home

FATHER
12. Name John Mucha
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland.

16 (a) Informant George Tlumok
(b) Address 303 S. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave

FEB 4 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1944 at 6:38 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1940 to Feb. 2 1944 and that I last saw her alive on Feb 2 1944

Immediate cause of death Myocardial insufficiency Duration. 2 YRS -
Due to ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Anthony Tlumok M. D.
Address 5217 York Rd Date signed 2/3/44

Correct age is especially important. Physicians please write out the words of month, day and figure.

13691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13691

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 Rogers Ave.

(c) Hospital or institution: Home for the Aged

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 Rogers Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sadie C. Ambrose.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1856

8. AGE: Years	Months	Days	If less than one day
87	9	20	hr. min.

9. Birthplace Balto Co. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Ezekiel Ambrose

13. Birthplace Maryland.

MOTHER 14. Maiden Name Mary Wilson.

15. Birthplace Maryland.

16 (a) Informant Emma B. Yobday.

(b) Address 1330 W 41st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4/44 (month) (day) (year)

(c) Cemetery or crematory Sater

Location Balto Co. Md.

18 (a) Funeral director C. Hengerer & Sons

(b) Address 11 E Chestnut Ave

FEB 4 1944

19 (a) Huntington Williams (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1943 to Feb 1 1944, and that I last saw h[illegible] alive on Feb 1 1944.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to	
Due to Arterio Sclerosis	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Arthur J. Danes M. D.

Address 800 W 33rd St Date signed 2-3-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 250

13692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

G 13692
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Dec. 21, 1943
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1754 W. Lexington Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME McCOY, Bassie (Robert)

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Daisy Davis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 23, 1892
8. AGE: Years 51 | Months 2 | Days 11 | If less than one day ..... hr. ..... min.
9. Birthplace Dunn, N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Glidden St. Helena Ave.

FATHER
12. Name Allen McCoy
13. Birthplace ? Dunn, N.C.

MOTHER
14. Maiden Name Louise ?
15. Birthplace Dunn, N. C.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5-44 (month) (day) (year)
(c) Cemetery or crematory Dunn N.C.
Location

18 (a) Funeral director Mrs Katie P. Williams
(b) Address 322 N. Schroeder St.

19 (a) (State registrar) (b) Huntington Williams, M.D.

FEB 4 1944
VS 130

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Feb. 2, 1944, at 8:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21, 1943, to Feb. 2, 1944, and that I last saw h..... alive on ..... 19 .....

Immediate cause of death Marked aspiration. Pneumonia lower lobes both lungs — Duration Sev. days

Due to Carcinoma of the tongue — Duration Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emmanuel G. Gladhill
Address Baltimore, Md. Date signed 2/3/44 (M. D.)

Va-14168

G 13693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G 13693

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Pierce St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Ernest Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widow

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30, 1893

8. AGE: Years	Months	Days	If less than one day
50	8	2	..... hr. ..... min.

9. Birthplace Howard Co. Md.
(Town, county, and state)
10. Usual Occupation Truck Helper
11. Industry or business Transfer Co.

FATHER
12. Name George Johnson
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Millie Kelley
15. Birthplace Howard Co. Md.

16 (a) Informant Vernon Johnson
(b) Address 633 N. Carrollton Ave.

17 (a) Burial (b) Date thereof Feb 5, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location .....

18 (a) Funeral director Wm Katie R. Williams
(b) Address 224 N. Schroeder St

19 (a) FEB 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1944, at 3.35 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wounds of chest

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb 2nd 1944 3 A M.
(b) Where did injury occur? 818 Pierce Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Stabbed

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 2 1944.

G 13694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G 13694

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Bal Co
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 E Jefferson St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James H. Waters

3 (b) If veteran, name war: N
3 (c) Social Security Account No. 219-01-5873

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1906

8. AGE: Years	Months	Days	If less than one day
37	11	11	hr. min.

9. Birthplace Virginia (Town, county, or state)
10. Usual Occupation Coast Guard / Police
11. Industry or business Fairfield Ship Yards

FATHER
12. Name (Not known) Waters
13. Birthplace Va

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Katherine E. Chew
(b) Address 133 N. Bradford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Md.

18 (a) Funeral director William Bok Inc
(b) Address 127 St. Paul St

19 (a) 2-7-1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3/44, 19, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1944, to 2/3 1944, and that I last saw him alive on 2/3/44 19.

Immediate cause of death: Peritonitis — Duration

Due to: Ruptured gastric ulcer

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within three months of death)

Major findings: Of operation: Abscess involving duodenum & gall bladder

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Mayer M.D.
Address Md. Gen'l Hosp. Date signed 2/3/44 M. D.

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13695

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 108

G 13695
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Johns Hopkins Hospital G 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 834 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry T. Petterton V

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	413-01-5819

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Cles Petterton
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1909

8. AGE: Years	Months	Days	If less than one day: hr.	min.
34	6	27		

9. Birthplace Norfolk Va.
(Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Bethlehem Steel Fairfield

FATHER
12. Name Jim Petterton
13. Birthplace Kentucky

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Cles Petterton
(b) Address 834 E. Preston St.

17 (a) Burial (b) Date thereof 2-5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodland Park
Location Baltimore

18 (a) Funeral director William Cook Inc.
(b) Address 1207 St. Paul St

19 (a) 2/4/44 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1944, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia Lobar,
Due to Chronic alcoholism.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature T. J. Wallenmeyer M.D.
Medical Examiner.
Date signed 2-3-44

VS 151

correct age in expectancy tables

13696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§ 2a

G 13696

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 E. 21st. Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. 21st. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Bonday

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Frederick A. Bonday
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6th 862

8. AGE: Years: 81 | Months: 4 | Days: 25 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At home
11. Industry or business Self

FATHER
12. Name William Schaufer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schuta
15. Birthplace "

16 (a) Informant Margaret Bonday
(b) Address 733 E. 21st St.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Balto. Md.

18 (a) Funeral director William Cook Sons
(b) Address 127 S. Paul St.

19 (a) 2/4/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1944 at 10 P M

21. I certify that I took charge of the remains described above, held an Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb. 2 1944

VS 151

13697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13697

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2412 Ken Oak Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2412 Ken Oak Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Wesley W. Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ella A. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16 1867

8. AGE: Years	Months	Days	If less than one day
76	2	16	hr. min.

9. Birthplace Somerset Co. Md.

(Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Great Eastern Oil Co.

FATHER 12. Name John C. Thomas

13. Birthplace Md.

MOTHER 14. Maiden Name Emily T. Revelle

15. Birthplace Md.

16 (a) Informant Mrs. Ella A. Thomas

(b) Address 2412 Ken Oak Rd

17 (a) Burial (b) Date thereof 2-5-44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

Filed FEB 4 1944 (b)

(Date of record)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd 1944 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 29 1943 to Feb 2 1944, and that I last saw h. alive on Jan 30 1944.

Immediate cause of death	Duration
Coronary Thrombosis	Indefinite
Due to Arterio-sclerosis & Hypertension	four yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. Barnard Lord M. D.

Address 1200 Garrison Blvd Date signed 2-2-44

G 13698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G 13698 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1914 W. Pratt St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4D —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME James Patrick Gannon

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widowed.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65	5	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Patrick J. Gannon
13. Birthplace Ireland

MOTHER
14. Maiden Name Marie E. Carr
15. Birthplace Ireland

16 (a) Informant Marie Gannon
(b) Address 1914 W Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)

(c) Cemetery or crematory Loy Calvert
Location Baltimore Md

18 (a) Funeral director Gallagher & Ryan
(b) Address 1217 E Fayette St

FEB 4 - 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1944 at 8 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gastric Hemmorhages from Peptic Ulcer

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature C. J. Sabinski M.D.
Medical Examiner.
Date signed 2/3/44

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13699
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wash (b) County
(c) City or town Washington DC
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Ruskin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martha Mize

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1883

8. AGE: Years	Months	Days	If less than one day
67	0	12 21	hr. min.

9. Birthplace Wash. DC (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jacob B Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Martha E. Fields
15. Birthplace Va.

16 (a) Informant Mrs W H. Hedgepeth
(b) Address 2305 Ruskin Ave

17 (a) Removal (b) Date thereof 2-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forest Lawn Cem
Location Richmond Va.

18 (a) Funeral director Wm Cook Sons
(b) Address 1209 N Paul st

19 (a) Feb 4 1944 (b)
(Date rec'd by registrar) Registrar

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1944 at 7:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1944 to 2/3 1944 and that I last saw h[illegible] alive on 2/3 1944

Immediate cause of death	Duration
Uremia	
Due to	
Due to	
Other Conditions Bronchopneumonia (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operations:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Steinberg
Address Sinai Hospital Date signed 2/4/44

G 13700

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13700 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Usual address 1733 E. Biddle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1733 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Luvenia Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1878

8. AGE: Years 65 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Epps
13. Birthplace Petersburg Va.

MOTHER
14. Maiden Name Mary Hea
15. Birthplace Md.

16 (a) Informant Amelia Jenkins
(b) Address 1733 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location

18 (a) Funeral director Mrs. Orford A. Ellsworth
(b) Address 1129 N. Carlton St.

FEB 4 - 1944 (Date rec'd by registrar) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1944, at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1944 to Feb 1 1944.
and that I last saw her alive on Jan 31 1944.

Immediate cause of death

Cardio-Renal — Duration unk

Due to

Due to

Other Conditions
Hemiplegia cerebral
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed Feb 5 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G 13701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered No. G 13701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 E. Monument Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nancy Ward Hardy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	married

6 (b) Name of husband or wife Moses —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1893

8. AGE: Years	Months	Days	If less than one day
50	7	29	hr. min.

9. Birthplace Georgia (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hardy Barramore
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary ?
15. Birthplace Unknown

16 (a) Informant Rose Hardie
(b) Address 818 N. Eden Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County Md.

18 (a) Funeral director Mrs. R. Adelhart & Sgt.
(b) Address 1129 N. Carolina St.

19 (a) FEB 4 1944 Huntington Williams
(Date rec'd by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1- 1944 at 2 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Poisoning by Arsenic As_2O_3

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb 1 1944 at 2 M.
(b) Where did injury occur? Investigated Police
(c) Did injury occur at home, on farm, industrial place, in public place? Law report 4/10/44 While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 2-1-44

Spec.—8-24-14—M. & T.—2000 Bks.

G 13702

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 13702

CERTIFICATE OF DEATH.

95 c 1 8

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4303 Fernhill Ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

2-FULL NAME Charles Howard Bullock

(Residence in Baltimore: No. same 4303 Fernhill Ave St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 19 (Day), 1867 (Year)

7-AGE, 76 yrs. 8 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION,
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Bureau of Assessments Baltimore City Dept

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Daniel J Bullock

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Catherine —

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca J Bullock

(Address) 4303 Fernhill Ave

15- FEB 4 1944

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 4 (Day), 1944 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1943 to Feb 4 1944 that I saw h[illegible] alive on Feb 3 1944 and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

Cardio Renal Decompensation

Arteriosclerosis Hypertension

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) .....

(Duration) .... yrs. .... mos. .... ds.

(Signed) R. O. Dellinger M. D.

Feb 4, 1944 (Address) Towson Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Feby 7, 1944

20-UNDERTAKER, Harry H Hancock ADDRESS 4204 Edgewood Rd

13703 #49212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Simmons St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcia McStanley
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife ✓
6 (c) If alive, give age ✓ years
7. Birth date of deceased (mo., day, yr.) 10-27-32
8. AGE: Years 11 Months 3 Days 7 If less than one day hr. min.
9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation ✓
11. Industry or business ✓
FATHER 12. Name James R. Stanley
13. Birthplace N.C.
MOTHER 14. Maiden Name Charlotte Meyers
15. Birthplace N.C.
16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5/44 (month) (day) (year)
(c) Cemetery or crematory Oakdale Cemetery
Location Washington N.C.
18 (a) Funeral director John Mitchell Sons
(b) Address 1900 Eastern Place
19 (a) FEB 4 1944 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1944 4 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944 to Feb 3 1944 and that I last saw h[illegible] alive on Feb 3 1944

Immediate cause of death	Duration
Cerebral abscess with cerebral purulent	
Due to Sinus extinction thrombosis	
Due to mastoid or benign	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jan 31, 1944
Major findings of operation: Multiple abscesses in right cerebral hemisphere
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ben W. Chambers M.D.
Address Johns Hopkins Hosp Date signed 2/3/44

VS 180

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13704 ✓ G 13704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2034 E. North ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 N. Washington (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Louis J. Lowry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Paper Manager

11. Industry or business

FATHER 12. Name Robt N Lowry

13. Birthplace Not known

MOTHER 14. Maiden Name Not known

15. Birthplace

16 (a) Informant Alice Lowry

(b) Address 2634 E North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3 1944 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Greenmount ave & Oliver st

18 (a) Funeral director Henry Lutz

(b) Address 1203 N. Broadway

19 (a) (Date received by registrar) (b) Livingston Williams, M.D., Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1944, to Feb 3 1944, and that I last saw him alive on Feb 3 1944.

Immediate cause of death	Duration
Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Just Finished M. D.

Address 1823 N. Front st. Date signed 2/4/44

VS 3

G 13705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

~~G 18768~~ Registered No. G 13705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Magnolia (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Beulah B , Malcolm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1892

8. AGE: Years 51 | Months 11 | Days 23 22 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jesse Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Knight
15. Birthplace Maryland

16 (a) Informant George Brown
(b) Address Magnolia Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof ~~Jan~~ Feb 4 1944 (month) (day) (year)
(c) Cemetery or crematory Abingdon Methodist
Location Abingdon Md

18 (a) Funeral director Howard R. McComas & Son
(b) Address Abingdon Md

19 (a) 2-4-1944 (b) [illegible] Harrington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1 1944 at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26-1944 to 2-1-1944, and that I last saw her alive on 2-1-1944.

Immediate cause of death Coronary Thrombosis — Duration 3 months

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Multiple myocardial infarction - Confirming

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L.D. Spalding M. D.

Address Church Home & Hospital Date signed 2/6/44

If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13706

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 E Randall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas D Rice

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-55-3500

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ollie M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 - 1883

8. AGE: Years	Months	Days	If less than one day
61	-	6	hr. min.

9. Birthplace Frederick Co Md (Town, county, and state)
10. Usual Occupation Machinist B & O
11. Industry or business

FATHER
12. Name James M Rice
13. Birthplace Md

MOTHER
14. Maiden Name Clara A. Wood
15. Birthplace Md

16 (a) Informant Mrs Ollie M Rice
(b) Address 212 E Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick ave

18 (a) Funeral director William M Marock
(b) Address 715 Light St

19 (a) 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3-44 19 , at 4:32 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25-44 19 , to 2-3-44 19 , and that I last saw h[illegible] alive on 2-3-44 19

Immediate cause of death Myocardial failure

Due to Bronchiopneumonia

Due to Uremia (obstructive)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C V Latimis, Jr M. D.
Address Univ. Hosp. Date signed 2-3-44

VS 150

G 13707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G 13707 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ? 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Park Av
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Margaret B Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Col	married

6 (b) Name of husband or wife Leroy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-27-1913

8. AGE: Years	Months	Days	If less than one day
30	8	7	hr. min.

9. Birthplace Bedford Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Beck
13. Birthplace Va

MOTHER
14. Maiden Name Cynthia Beck
15. Birthplace Va

16 (a) Informant Richard Lindsay
(b) Address 1203 Park Av

17 (a) Burial (b) Date thereof 2-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Bedford Va

18 (a) Funeral director Mr. Geo. H. Holland
(b) Address 1631 Druid Hill Av.

19 (a) (Date received by Registrar) (b) Huntington Williams M.D.

FEB 4 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3 1944 at 2:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1944 to 2-3 1944, and that I last saw h[er] alive on 2-1 1944.

Immediate cause of death Generalized Carcinosis — Duration

Due to Ulcerated Tuberculous Abscess

Due to Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 1-27-44
Major findings of operations Generalized Carcinosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Lindsay
Address 808 N Fremont Date signed 2-5-44

Please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13708 V

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

Registered No. G 13708

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md Gen Hosp 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Henry ave, Sagtbury
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Pulanski Mary A. Pilarski

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex f

5. Color or race w

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Andrew J.

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 3-25-'89-84

8. AGE: Years 54 Months 10 Days 8 If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Hsewf

11. Industry or business —

MOTHER / FATHER

12. Name Ignatius Zawiski

13. Birthplace Poland

14. Maiden Name

15. Birthplace Poland

16 (a) Informant Andrew Pulanski

(b) Address same (33 Henry Ave)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 7 44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director M. W. E. Dippel's Sons

(b) Address 7110 Belair Rd.

19 FEB 4 1944 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 19 44, at 8 14 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 19 44, to 2-3 19 44, and that I last saw h[illegible] alive on 2-3 19 44.

Immediate cause of death Aspiration Pneumonia — Duration 2 da.

Due to Obstructive vomiting

Due to Intestinal obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D'Emmanuele M.D.

Address Md Gen Hosp Date signed 2-3-44

VS 1

G 13709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13709 Registered No.

PLEASE WRITE correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Lume
(c) Hospital or institution: University 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flaunce Saunders

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Bl. | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24-01

8. AGE: Years 42 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Soldering

11. Industry or business Western House

FATHER
12. Name William Saunders
13. Birthplace Md

MOTHER
14. Maiden Name Pearl Wright
15. Birthplace Md

16 (a) Informant Pearl Goldsborough
(b) Address 1114 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Sam'l F. Chase & Son
(b) Address 638 N. Gilmor St

19 (a) Date received (b) Registrar

FEB 4 - 1944 VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1944 at 2 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1944 to Feb. 3 1944, and that I last saw h alive on Feb. 3 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Brain edema Arteriosclerosis

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. C. Palmer M. D.

Address University Hospital Date signed 2/3/44

3710 FOEHRLKOLB G 13710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 159

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore & Fairmount Streets.
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write the name of the town)
(d) Street No. 405 S Cornwall St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Faehrkolb.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr	min.
4 days.				

9. Birthplace Church Home Hospital. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Joseph Faehrkolb.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hannah Michael
15. Birthplace Maryland

16 (a) Informant mother
(b) Address 405 S. Cornwall St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 4 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 4 1944 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2, 1 1944, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29, 1944, to Feb 2, 1944, and that I last saw him alive on Feb 2, 1944.

Immediate cause of death Respiratory failure

Due to prematurity.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Steuart Hatch, M. D.
Address CAH. Date signed 2/3/44

0710

G 13711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13711 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1923 Guilford Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Paul E. Leatherbury

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Ann McCormick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1874

8. AGE: Years	Months	Days	If less than one day
69	9 2	26 5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name John E. Leatherbury
13. Birthplace Md.

MOTHER
14. Maiden Name Maria L. Doud
15. Birthplace Md.

16 (a) Informant Rev. John B. Leatherbury
(b) Address 1923 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John L. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 FEB 3 1944 Thurlington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1944, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to Feb. 2 1944, and that I last saw him alive on Feb. 1 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 24 hours
Due to Arterio Sclerosis - Generalized — years
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry L. Hewson M. D.
Address 20 E. Preston St. Date signed 2/4/44

L. Hewson

Street age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13712 Registered No. 100 B

1. PLACE OF DEATH: 600 Jasper Street
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Jasper Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthews J. SMITH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 5 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 914 Druid Hill Ave

FEB 4 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1944, at M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Thrombophlebitis, chronic
left leg.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature T. H. Wollenweber M.D.
Asst. Medical Examiner.
Date signed 1-28-44

VS 151

G 13713 Copy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 N. Castle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 N. Castle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Rommell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Charles F. Rommel
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1877

8. AGE: Years	Months	Days	If less than one day
66 65	4	19	hr min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Frank Becker
13. Birthplace Austria

MOTHER
14. Maiden Name Not known
15. Birthplace Austria

16 (a) Informant Charles F. Rommel
(b) Address 816 N. Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md

18 (a) Funeral director Frank Brach & Son
(b) Address 900 N. Charles St

19 (a) FEB 4 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1944 at 9:55 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed 2-3-44

G 13714 KOLARIK 50 G 13714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 N. Glover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 to yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 N. Glover St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Kolarik

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Kolarik 6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Feb. 2 1875

8. AGE: Years 69 | Months — | Days 2 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

MOTHER / FATHER

12. Name Frank Kruml

13. Birthplace Bohemia

14. Maiden Name Anna Bokac

15. Birthplace Bohemia

16 (a) Informant John Kolarik

(b) Address 721 N. Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Location Balto Md

18 (a) Funeral director Frank Brachbon

(b) Address 900 N. Chester St, 5,

19 FEB 4 - 1944 (b) Huntington Williams M.D. (Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1944, at Com. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1941, to Feb. 4 1944, and that I last saw h.. alive on Feb. 3 1944.

Immediate cause of death (a) Acute Myocardial Failure c Pulmonary Edema — Duration 12 hours

Due to (b) Carcinoma of Breast c Generalized Metastasis — Duration 2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M. D.

Address 2413 E. Monument St Date signed 2/4/44

G 13715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13715 Registered No. 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Week

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Goldsboro (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anna O'Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas O'Berry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1887

8. AGE: Years	Months	Days	If less than one day
56	8	6	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Mr. Virginius Land
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Mays
15. Birthplace Va.

16 (a) Informant Thomas O'Berry (Husband)
(b) Address Goldsboro N.C.

17 (a) Removal (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery Willow Dale
Location Goldsboro N.C.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, Registrar

4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1944, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/ 1944, to 2/4 1944, and that I last saw her alive on 2/4 1944

Immediate cause of death: Pul congestion shock
Cardio-respiratory failure
Due to Operation
Due to Coronary thrombosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 2/4/44
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Van Lill III M. D.
Address Union Memorial Hosp Date signed 2-4-44

B correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

G 13716
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Poplar Grove St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma G. Larrimore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband or wife C. S. Larrimore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 16 1871

8. AGE: Years	Months	Days	If less than one day
72	10	16	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Sally

FATHER 12. Name John Goodluck
13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Blizzard
15. Birthplace Balto. Co. Md.

16 (a) Informant W. T. Larrimore Son
(b) Address 809 N. Harrison St. Wilmington Del.

17 (a) Burial (b) Date thereof 2/5/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 FEB 5 1944
(Date received by local registrar)
Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd 1944 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Feb 2 1944 and that I last saw him alive on Feb 2 1944

Immediate cause of death Cardiac Insufficiency
Due to Senility
Due to Arterio Sclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Duration 7 days, 4 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin L. Brosh M. D.
Address 2662 Fulton Ave Date signed 2-4-44

correct age if apparently improperly written; physicians please write the causes of death clearly and legibly.

13717

T.H 85342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 Parrish St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Matilda Snowden
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Lawrence (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22nd/1901

8. AGE: Years	Months	Days	If less than one day
42	7 6	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name Dennis Brooks
13. Birthplace ?

MOTHER
14. Maiden Name Harriet Marshall
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St
FEB 5 - 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1944, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1943 to 2/3 1944.
and that I last saw h alive on 2/3 1944.

Immediate cause of death
Pulmonary TBC

Due to

Due to

Other Conditions Polyuremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Hall M. D.
Address B C H Date signed 2/4/44

Correct age is especially important. Physicians, please write the number of years in this space.

13718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944

Registered No. G 13718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harvard + Madison
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Walbrook Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? [redacted] years

3 (a) FULL NAME Henry Slothower

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Nannie E. Slothower

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1861

8. AGE: Years 82 | Months 1 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Sugar Broker

11. Industry or business

FATHER
12. Name George Slothower
13. Birthplace Balto.

MOTHER
14. Maiden Name Marie Randall
15. Birthplace Balto.

16 (a) Informant Miss Doris E. Slothower (daughter)
(b) Address 3307 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart & Moman Co.
(b) Address 108 W. North Ave.
(c) Interior for Williams, M.D.

FEB 5 - 1944
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1944, at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1943, to Feb 2 1944, and that I last saw h/Pt. alive on Feb 2 1944.

Immediate cause of death: Angina pectoris — Duration

Due to: General arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Kenyon Williams M. D.
Address Md. Gen. Hosp. Date signed Feb. 3, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 1

3719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 13719
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 Light St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Beatrice Estell Webb

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 404-14-2257

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1924

8. AGE: Years 19 Months 9 Days 3 If less than one day hr. min.

9. Birthplace Floyd Ct. Auxier Kentucky (Town, county, and state)

10. Usual Occupation Drill press operator

11. Industry or business Bendix

FATHER
12. Name George Webb
13. Birthplace Fort Gay West Virginia

MOTHER
14. Maiden Name Anna Stratton
15. Birthplace Floyd Ct. Kentucky

16 (a) Informant Mrs. Anna Webb
(b) Address 909 Light St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 6 44 (month) (day) (year)
(c) Cemetery or crematory Auxier
Location Kentucky

18 (a) Funeral director Fred A. Krause & Son
(b) Address 1216 E. Charles St.

FEB 5 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1944 at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15/43 to 2/4/ 1944 and that I last saw her alive on 2/3/ 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Leiter M.D.
Address 1226 Hanover St Date signed 2/5/44

G 13720

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13720 Registered No. 30E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 W. Mulberry St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Estelle Burton

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-11-1899

8. AGE: Years	Months	Days	If less than one day
44	4	21	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name Kennard

13. Birthplace ?

MOTHER 14. Maiden Name Ward

15. Birthplace Md.

16 (a) Informant Rosa Banks

(b) Address King Wms Co. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) FEB 5 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2- 1944, at 6 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1944, to 19..., and that I last saw her alive on 19...

Immediate cause of death: Cerebral hemorrhage — Duration

Due to General syphilis

Due to Luetic cardio-vascular dis.

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Friedman M. D.

Address 1319 Linden Ave Date signed

FRIEDMAN

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3721 283961 JO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G 13721

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 335 W. Camel St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Derrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1884

8. AGE: Years 59 | Months 8 | Days 15 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Derrick
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Dorsey
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory St. Thomas
Location

18 (a) Funeral director A. Halstead Dallabe
(b) Address 918 Dundalk Ave.

19 (a) FEB 5 1944 (Date received by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1944, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1943, to 2/4 1944, and that I last saw her alive on 2/4 1944.

Immediate cause of death Pulmonary Tuberculosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify) (specify place)
(e) Means of injury

Signature Earl R. Kinney M. D.
Address Balt. City Hospitals Date signed 2/4/44

13722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13722
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 N. Central Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N. Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriet Purvines

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
86				

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs Lottie Lee
(b) Address 507 N. Central Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

FEB 5 - 1944 (Date rec'd by Registrar) (b) Huntington Williams MD (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, '44 19 , at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11.6 1942 to 2.3 1944, and that I last saw her alive on 1.28 1944.

Immediate cause of death: Hypertensive cardio-renal disease — Duration: ? years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne

Address 1500 E. Madison St Date signed 2-5-44

Please write clearly. Physicians: please write the causes of death clearly and legibly. Also correct age is especially important.

13723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13723
Registered No. 1210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1359 Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1359 Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Hill Stewart

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widowed

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-1880

8. AGE: Years	Months	Days	If less than one day hr.	min.
63 62	1	4		

9. Birthplace St Marys Co. Md (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Md

16 (a) Informant Mary E Hill
(b) Address 1359 Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 7 44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location St. Marys County Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pamna ave
2-5-1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2- 1944, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1944 to Feb 2 1944.
and that I last saw h[illegible] alive on 2-2 1944.

Immediate cause of death Pneumonia — Duration 3 da

Due to Bronchitis

Due to Nephritis - Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm R Boarman M.D.
Address 1135 Gilmor / Date signed 2/3/44

Please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

13724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 13724 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard + Madison
(c) Hospital or institution:
Maryland General 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6014 York Rd (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Wesley Green Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Katherine Blanch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Cole.
13. Birthplace Virginia.

MOTHER
14. Maiden Name Margaret Mauls.
15. Birthplace Penn.

16 (a) Informant Dr Hallam Cole
(b) Address 6614 York Rd

17 (a) (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory Dunkirk,
Location Hood Depot

18 (a) Funeral director Harry F Hoffpauir
(b) Address 4101 Edmondson Ave

19 (a) FEB 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1944 at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1944, to Feb. 2 1944, and that I last saw him alive on Feb 2 1944.

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. Herman Williams M. D.
Address Md. Gen. Hosp. Date signed Feb 2, 1944

VS 3

correct age is especially important. Physicians: please write the causes of death clearly.

G 13725

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 13725
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Floyd Tubbard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Cora Tubbard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 12, 1884

8. AGE: Years 59 | Months 11 | Days 23 | If less than one day: hr. min. 22

9. Birthplace Michigan (Town, county, and state)

10. Usual Occupation Truck driver

11. Industry or business self

FATHER
12. Name Joseph Tubbard
13. Birthplace Michigan

MOTHER
14. Maiden Name Hopkins
15. Birthplace Michigan

16 (a) Informant Mrs Margaret Millar
(b) Address 202 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Washington Blvd.

18 (a) Funeral director John F Cowan & Son
(b) Address 2403 Eutaw St.

FEB 5 - 1944 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 4th 1944 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1944 to Feb 4 1944 and that I last saw him alive on Feb 3 1944.

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to

Other Conditions Cardiac Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert Scognetti M. D.

Address 1724 W Lombard St Date signed 2-4-44

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G 13726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 13726

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert.
(c) Hospital or institution: Union Memorial Hospital 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 R. + Stony Run La. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DR. EDWARD BENNETT MATHEWS.

3 (b) If veteran, name war V

3 (c) Social Security Account No. V

4. Sex M

5. Color or race white

6 (a) Single, (married) widowed, or divorced.

6 (b) Name of husband or wife Helen N. Mathews

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1869.

8. AGE: Years 74 | Months 5 | Days 18 17 | If less than one day ..... hr. ..... min

9. Birthplace Maine. (Town, county, and state)

10. Usual Occupation Professor Geology

11. Industry or business Johns Hopkins.

FATHER
12. Name Jonathan B. Mathews
13. Birthplace Maine.

MOTHER
14. Maiden Name Sophia Shailer
15. Birthplace Conn

16 (a) Informant Helen N. Mathews
(b) Address Lombardy Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7/44 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cem.
Location Troy N.Y.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19. Filed FEB 5 - 1944 (Date rec'd by Registrar) (Signature) for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4, 1944, at 6:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4, 1944 to Feb 4, 1944, and that I last saw him alive on Feb 4, 1944.

Immediate cause of death: Cardiac failure. — Duration: 1 hr.

Due to cerebral edema. — 1 hr.

Due to Cerebro-vascular accident. — 2 wks.

Other Conditions: arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: cerebral edema.

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Chaffee M. D.
Address Union Mem. Hosp. Date signed 2/5/44

VS 150

Physicians, please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. C 13727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. & John ST.
(c) Hospital or institution: Hospital for Women of Maryland 9 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Maryland
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4027 Deepwood Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Ridgely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Ruxton Moore Ridgely
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	1	20		

9. Birthplace Baltimore, Maryland (Town, county and state)
10. Usual Occupation None
11. Industry or business Ellicott City, Md.

FATHER
12. Name George R. Gaither
13. Birthplace Ellicott City, Md.

MOTHER
14. Maiden Name Rebecca Hanson Dorsey
15. Birthplace Ellicott City, Md.

16 (a) Informant Mr. Ruxton Ridgely (son)
(b) Address 4027 Deepwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Ellicott City, Md.

18 (a) Funeral director John O. Mitchell, Undertaker
(b) Address 1900 Eutaw Place.

19 (d) FEB 5 1944 Huntington Williams, M.D.
(Registrar's signature) for Robert Jr. Graham, by Howard J. Mackey, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1944, at 11:45 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 27 1944 to Feb. 4 1944, and that I last saw her alive on Feb 4 1944.

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to	
Due to Fractured right femur	9 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-27-44
Major findings of operation: Fracture of head of right femur
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 9/2
(b) Date of occurrence Jan. 27, 1944 at 7 A.M
(c) Where did injury occur? Balto. (City or town) Balto. (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped on rug & fell
23. Signature Huntington Williams M.D.
Address Women's Hosp. Date signed 2-4-44

VS 8

G 13728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G 13728

correct age is especially important, and the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 E.Federal St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 E.Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A.Betts

3 (b) If veteran, name war --
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Cecelia Betts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.18,1858

8. AGE: Years 85 | Months 3 | Days 15 | If less than one day: hr. min

9. Birthplace Balto.Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name -- Betts
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name --
15. Birthplace Balto.Md.

16 (a) Informant Mrs.Alice Drews
(b) Address 1209 E.Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.7/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto.Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) FEB 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb.3rd.1944 19 ..., at 7:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1943, to Feb 2 1944, and that I last saw him alive on Feb 2 1944.

Immediate cause of death Arteriosclerotic Gangrene
Due to Cerebral Thrombosis — Duration: 1 year, 6 mos.
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Granger M.D.
Address 702 E Fayette Date signed 2-4-44

VS 8

13729 48649

G 13729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N. Linwood (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Theodore L. Codd

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-07-8619

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lula

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5-11-02

8. AGE: Years 41 | Months 8 | Days 22 | If less than one day hr. ..... min. .....

9. Birthplace Md (Town, county and state)

10. Usual Occupation Clerk

11. Industry or business .....

FATHER
12. Name Stephen Codd
13. Birthplace Md

MOTHER
14. Maiden Name Jane Kirby
15. Birthplace Md.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address .....

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Woodland Mem Pk
Location Baltimore Md

18 (a) Funeral director Philip Henry Sard
(b) Address 2024 Eutaw St

19 (a) Filed FEB 5 1944 (b) Registrar Huntington Williams M.D.

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 19 44 at 2 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 19 44 to Feb 3 19 44, and that I last saw him alive on Feb 3 19 44

Immediate cause of death Lobar pneumonia RUL, RML, LLL, ? LUL

Due to ? RLL due to

Due to ~~staphylococcal~~ unidentified organism

Other Conditions ? GI hemorrhage, terminal

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature John R. Bunningham M.D.
Address JHH Date signed 2-3

13730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 13730 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hospital
(c) Hospital or institution: 33rd and Calvert Streets
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State ... (b) County ...
(c) City or town ... (If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME Baby Boy Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1943

8. AGE: Years | Months | Days: 6 | If less than one day: ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business ...

FATHER
12. Name Mr. Chas. H. Miller
13. Birthplace Maryland

MOTHER
14. Maiden Name Pauline Richardson
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address ...

17 (a) Cremation (Burial, cremation, or removal) **(b) Date thereof** ... (month) (day) (year)
(c) Cemetery or crematory Union Memorial Hosp
Location Calvert & 33rd Sts.

18 (a) Funeral director ...
(b) Address Huntington Williams, M.D.

FEB 5 1944
(Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1943, at 9 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1943, to Dec. 18 1943, and that I last saw him alive on Dec. 18 1943.

Immediate cause of death Respiratory failure — Duration: 2 hr.

Due to Pneumonia, bronchial — 2 da.

Due to Prematurity

Other Conditions ...

(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

... of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature James N McCosh M. D.
Address Union Memorial Hosp. **Date signed** 12-18-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

G 13731 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 W. 40th St
(c) Hospital or institution:
Home of Incurables 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos. 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William George Mac Callum
3 (b) If veteran, name war
3 (c) Social Security Account No. --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18 1873

8. AGE: Years 70 | Months 9 | Days 16 | If less than one day: hr. min. 5

9. Birthplace Dunnville Canada (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name George Mac Callum
13. Birthplace Ontario, Canada

MOTHER
14. Maiden Name Florence Eckins
15. Birthplace Ontario Canada

16 (a) Informant Mrs Herbert Rand
(b) Address 50 Fallon St. Cambridge Mass.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1944, at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1943 to Feb. 3 1944, and that I last saw him alive on Feb. 2 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage / Left Hemiplegia	7 hours
Due to: Hypertensive Cardio Vascular Disease	7 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolff M.D.
Address 11 E. Chase St. Baltimore Maryland Date signed 2/3/44

G 13732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G 13732 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3611 Garrison Blvd.
(c) Hospital or institution: Mt Wilson Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2611 Garrison Blvd. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Foster U. Gift (Foster Ulysses Gift, D. D.)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, (married) widowed, or divorced.

6 (b) Name of husband or wife Carrie Swengee Gift

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1871

8. AGE: Years 72 | Months 8 | Days 9 | If less than one day: hr. min.

9. Birthplace Pennsylvania (Paxtonville.) (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business Church

FATHER
12. Name David W. Gift
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Boderay
15. Birthplace Pennsylvania

16 (a) Informant Carrie Gift
(b) Address 2611 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 5 - 1944 (Date rec'd by registrar) (b) Burial Permit for William [illegible]

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1944 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29 1944 to 2/4 1944, and that I last saw her alive on 2/4 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to Contra-mantar accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Mt Wilson Hosp. Date signed 2/5/44 M. D.

13733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Chatham Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen L. Shaffer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frederick L.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1866

8. AGE: Years	Months	Days	If less than one day
77	3	17	hr. min.

9. Birthplace Baltimore, Baltimore Co, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Smith
13. Birthplace England

MOTHER 14. Maiden Name Josephine Tilyard
15. Birthplace Baltimore

16 (a) Informant Mr. Arthur F. Shaffer
(b) Address 3804 Chatham Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 5 - 1944 (Date rec'd by registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1944 at 3:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1944 to 2-4 1944 and that I last saw her alive on 2-4 1944.

Immediate cause of death Cardiorespiratory failure

Due to Cerebrovascular Accident

Due to Hypertensive Cardiovascular disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Van Dill II M. D.

Address Union Memorial Hospital Date signed 2-7-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13734 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3316 FOSTER AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-11
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3316 FOSTER AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN VOGEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife CAROLINE VOGEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 26 1870

8. AGE: Years	Months	Days	If less than one day
73	10	7	hr. min

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation RETIRED PAINTER
11. Industry or business FOR SELF.

FATHER
12. Name ADAM VOGEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant BERNARD VOGEL (SON)
(b) Address 5301 McCormick Ham. Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 7/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) FEB 5 1944 (Date received by Registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 2 1944, at 4/45 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1942, to Feb 2 1944, and that I last saw h[illegible] alive on Feb 2 1944.

Immediate cause of death Uterine chorder
C.V. Disease Coronary
Thrombosis
Due to Myocardial Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:

of autopsy: None

Duration
1-18-42
June 18/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E A Schimenek M. D.
Address 642 S. Eutaw Date signed 2-9-44

13735 Floyd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C 13735

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 W Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 W Fairmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Florence Floyd

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 4-1-1895

8. AGE: Years 48 | Months 10 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Domestic

FATHER
12. Name Rastus Wilson
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Scarboro
15. Birthplace Va.

16 (a) Informant Grace F Floyd (daughter)
(b) Address 727 W Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County Md

18 (a) Funeral director Charles H Hawkins
(b) Address 512 N. Carrollton Ave

19 (a) Feb 5 1944 (Date received by local registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1944 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1944 to Feb. 2 1944 and that I last saw h[illegible] alive on Feb 2 1944

Immediate cause of death
Cerebral Hemorrhage — Duration 3 days
Due to Hypertension
Due to Overwork
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W Leatherman Jr M.D.
Address 426 N. Johnson St Date signed 2/8/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

13736
448701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13736
Registered No.

61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Asbury Madden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-14-78

8. AGE: Years 65 | Months 2 | Days 20 | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Amos Madden
13. Birthplace Md

MOTHER
14. Maiden Name Martha
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Mt. Pleasant
Location Owings Mills Md

18 (a) Funeral director Mrs. Geo. K. Holland
(b) Address 1631 Druid Hill Ave. Huntington Williams, M.D.

19 FEB 5 - 1944
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1944, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 4 1944, and that I last saw h/M alive on Feb 4 1944.

	Immediate cause of death	Duration
	(1) Lobular Pneumonia	
due to	(2) Bronchial Pneumonia	
	(3) Chronic Myocarditis	
Due to	(4) Arteriosclerosis	
	(5) Urinary tract infection	
Due to	(6) Arthritis, generalized	
Other Conditions	(7) Amputation, right above knee	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Benesan
Address J Hopkins Date signed 2-4-43 M D

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 13737 Registered No. 1190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Baby Boy Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/8/44

8. AGE: Years	Months	Days	If less than one day
		26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James Gross
13. Birthplace md

MOTHER
14. Maiden Name Marie Gross
15. Birthplace md.

16 (a) Informant Marie Gross
(b) Address 1334 Argyle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemty
Location Anne Arundel Co.

18 (a) Funeral director Robert E. Jennings
(b) Address 1501 Madison ave

19 (a) Huntington Williams, M.D. (Registrar)
(b) Date received 1944 (Registrar)

B 6

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1944, at 1:42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1944 to 2/3 1944, and that I last saw him alive on 2/3 1944

Immediate cause of death: Infantile Diarrhea — Duration 5 days

Due to

Due to

Other Conditions Prematurity
Cellulitis of back
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Haught M. D.
Address Univ. Hosp. - Balt. Md. Date signed 2-7-44

Please write plainly, with indelible pencil. Do not use abbreviations except age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13738

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 13738 Registered No.

CERTIFICATE OF DEATH X 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green + Redwood Sts
(c) Hospital or institution:
University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Nitro
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles B. Marshall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Married

6 (b) Name of husband/wife Margaret A. Blemiller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1892

8. AGE: Years	Months	Days	If less than one day
51	6	3	hr. min.

9. Birthplace W. Va (Town, county, and state)
10. Usual Occupation physician
11. Industry or business

FATHER
12. Name Thomas B. Marshall
13. Birthplace Va

MOTHER
14. Maiden Name Alice P. King
15. Birthplace Va

16 (a) Informant Mrs Margaret A. Marshall
(b) Address Nitro W. Va

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 2/5/44 (month) (day) (year)
(c) Cemetery or crematory
Location Nitro, W. Va

18 (a) Funeral director Harry H. Witzke
(b) Address 4401 Edmondson Ave

FEB 5 - 1944 (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1944 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1944 to 2/5 1944 and that I last saw h[illegible] alive on 2/5 1944.

Immediate cause of death Acute coronary thrombosis with possible myocardial rupture — Duration
Due to (Gradually) fall in blood pressure
Due to sympathectomy
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. A. Hengaw
Address University Hosp. Date signed 2/5 M. D.

Transcribed for Whitehurst, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13739 Registered No. 46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Driveway and 31st St., 6
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Alexandria (If outside city or town limits, write RURAL and give town)
(d) Street No. Wellington Villa, Route 1 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. GRACE ELLEN FINK

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FeMale	white	Married

6 (b) Name of husband or wife Ola E. Fink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/8/85

8. AGE: Years	Months	Days	If less than one day hr.	min.
58	1	27		

9. Birthplace FREDERICK COUNTY, MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Charles Fogle
13. Birthplace Frederick County, Maryland

MOTHER
14. Maiden Name Martha Bowers
15. Birthplace Frederick County, Maryland

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Md.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Alexandria, Va.

18 (a) Funeral director V. S Emily.
(b) Address 809 King St Alex. Va.

19 (a) 1944 (b) [illegible] (Signature of registrar) Washington, Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1944, at 4:05a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31, 1943, to Feb. 5, 1944, and that I last saw him alive on Feb. 5, 1944.

Immediate cause of death: Adenocarcinoma of stomach with generalized abdominal xxxxx metastases — Duration: 4 mo.
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature J. Calvin M. D.
Address US Marine Hospital Baltimore, Md. Date signed 2/5/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 S. Haven St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 94 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 S. Haven St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Antonio Esposito

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Saveria Esposito
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1876

8. AGE: Years	Months	Days	If less than one day
67	8	15	hr. min.

9. Birthplace Napoli Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Sebastiano Esposito
13. Birthplace Italy

MOTHER 14. Maiden Name Maria Ferrinco
15. Birthplace Italy

16 (a) Informant Andrew A. Esposito (Son)
(b) Address 220 S. Haven St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (b) (Registrar) Registrar

FEB 9 1944

VS 8

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1944, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1943, to Feb. 4, 1944, and that I last saw him alive on Feb. 2, 1944.

Immediate cause of death	Duration
Myocarditis (chronic)	2½ yrs
Due to	
Due to	
Other Conditions Bronchial Asthma	2

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene R. Perazzo M. D.
Address 514 Drury Lane Date signed 2/4/44

G 13741 ✓ G 13741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 Hawthorne Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Hawthorne Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harrison Weymouth

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Sara Snowden
6 (c) If alive, give age 2 years
7. Birth date of deceased (mo., day, yr.) Feb 11 1878

8. AGE: Years	Months	Days	If less than one day
65	11	25	hr. min.

9. Birthplace Lowell Mass (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Harrison Grey Weymouth
13. Birthplace Maine
MOTHER 14. Maiden Name Elvira L. Currier
15. Birthplace N. H.

16 (a) Informant Sara Snowden Weymouth
(b) Address 108 Hawthorne Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W Dukeman Son Co
(b) Address McCulloh & Eutaw Sts

19. (a) (Entered by registrar) (b) Registrar

FEB 8 1944 Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5th 1944, at 0 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4th 1944, to Feb 5th 1944, and that I last saw h~~im~~ alive on Feb 5th 1944.

Immediate cause of death	Duration
Coronary Occlusion	24 hrs.
Due to Uremia Acidosis	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Shallad M. D.
Address 1300 N. Calvert St Date signed Feb 5 1944

G 13742 ✓ G 13742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2057 W. Lexington St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2057 W Lexington St
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country —

3 (a) FULL NAME John H Lupton

3 (b) If veteran, name war —

3 (c) Social Security Account No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carrie R. Lupton
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov 13 1885

8. AGE: Years	Months	Days	If less than one day
58	2	22	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Maintenance Police Dept

FATHER
12. Name Henry E. Lupton
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Morton
15. Birthplace Baltimore Md

16 (a) Informant Carrie R. Lupton
(b) Address 2057 W Lexington St

17 (a) Buried (b) Date thereof 2/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director F. A. Huppert & Son
(b) Address Baltimore & Monroe Sts
Washington Williams, M.D.

19 (a) _____ (b) _____
(Date received by registrar) Registrar

FEB 8 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1944 to 2/7 1944
and that I last saw h[illegible] alive on 2/2 1944

Immediate cause of death Coronary Thrombosis — Duration 2 d-y-s

Due to _____

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)
Date of operation _____
Major findings of operation: _____

of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)
(e) Means of injury _____

23. Signature Charles J. Tuberi Jr.
Address 5317 Baltimore Nat'l Bk Date signed 3/7/44 M. D.

Reinstated
[illegible]

G 13743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13743 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 Lemmon St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Lemmon St (If rural give location)
(e) Citizen of foreign country? — (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Katherine L. Purcell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John J. Purcell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 28-1855

8. AGE: Years	Months	Days	If less than one day
88	2	7	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Joseph Lint
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Butler
15. Birthplace England

16 (a) Informant Ed Mc Boylan
(b) Address 602 Lemmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director F. B. Shippet & Son
(b) Address Eutaw Place & Lanvale

19 (a) FEB 6 1944 (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1944 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1944, to Feb. 4 1944, and that I last saw h ed alive on Feb. 4 1944.

Immediate cause of death	Duration
acute myocarditis	
Due to Chronic interstitial Nephritis	
Due to Lobar pneumonia (left)	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Charles L Nentodt M. D.
Address 1730 Linden ave Date signed 2/5/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13744 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 St Paul St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 11
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 St Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Aleta Linthicum

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: J. Chas. Linthicum
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Abt-1864

8. AGE: Years: Abt 80 | Months: — | Days: — | If less than one day: — hr. — min.

9. Birthplace: Saratoga Springs-NY
(Town, county, and state)

10. Usual Occupation: nurse

11. Industry or business: none

MOTHER / FATHER
12. Name: Dr. John L. Perry
13. Birthplace: New York State
14. Maiden Name: Hamit Sadler
15. Birthplace: New York State

16 (a) Informant: Helen P. Linthicum (niece)
(b) Address: 3003 Alameda Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md.

18 (a) Funeral director: Stewart Mowen Co.
(b) Address: 108 W Monument

19 (a) (Signature of Registrar) (b) per sig for Williams, M.D. Registrar

FEB 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1944 at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Feb 4 1944.
and that I last saw her alive on Feb 3 1944.

Immediate cause of death: Bronchitis
Due to: Pneumonia
Due to: Cerebral Hemorrhage
Due to: Senile Decay
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

Duration: 3 days; Indefinite; 7 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. L. Lemmon M. D.
Address: Walter W. Lee Date signed: Feb 4 1944

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13745 G 13745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) (Life) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 St Paul St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Victor Koehler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	~~Widower~~ Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1868

8. AGE: Years	Months	Days	If less than one day
75	6	17	hr. min.

9. Birthplace Maryland (Town, county, or state)
10. Usual Occupation Chart Envelope
11. Industry or business manufacturing

FATHER
12. Name Herman Koehler
13. Birthplace Maryland

MOTHER
14. Maiden Name Herman Josephine Mann
15. Birthplace Maryland

16 (a) Informant Miss Florence Sumner (niece)
(b) Address 5720 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)
(c) Cemetery or crematory Mullikin
Location Frederick - Md.

18 (a) Funeral director Sherwood Moore Co.
(b) Address 1084 Wilkens Ave.

19 (a) 2-6-1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1944 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30- 44 to 2-5 44 and that I last saw him alive on 2-5 1944.

Immediate cause of death: Cardiorespiratory failure
Due to ~~Pulmonary~~ tuberculosis
Due to Bronchogenic carcinoma ?

Duration

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bronchogenic carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill 1st
Address Union Memorial Hosp Date signed 2-6-44 M. D.

Huntington Williams, M.D.

corrected age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13746 Registered No. 121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore-5, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N. Glover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BARBARA BIEBEL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Lawrence (deceased) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1870

8. AGE: Years	Months	Days	If less than one day
73	3	10	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frank Kuran
13. Birthplace Germany

MOTHER
14. Maiden Name Agatha ?
15. Birthplace ?

16 (a) Informant Mrs. Theresa Machovec
(b) Address 710 N. Glover st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 6 Vs 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATE

20. DATE OF DEATH Feb. 5 1944 at 1:30 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from 2/3 1944 to 2/5 1944 and that I last saw h alive on 2/5 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Generalized peritonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/3/44

Major findings of operation: Ruptured appendix & Generalized peritonitis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Blevins
Address Mercy Hosp. Date signed 2/6/44 M. D.

G 13747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 13747 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution: Hebrew Home for Aged & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring & Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Blumberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day hr.	min.
64				

9. Birthplace Russia. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph.
13. Birthplace Russia.

MOTHER
14. Maiden Name Lapsky
15. Birthplace Prague

16 (a) Informant Dept. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Doswell Ave

18 (a) Funeral director Jack Levin Inc.
(b) Address 1439 E. Balto St

FEB 6 1944

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1944 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17/ 1937 to 2/5/ 1944, and that I last saw her alive on Feb. 5 1944.

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to

Other Conditions Diabetes mellitus arthritis deformans
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Levin M. D.
Address Levindale Date signed

G 13748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13748 / 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3219 Woodland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 Woodland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rose Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Abraham Davis
13. Birthplace Poland

MOTHER
14. Maiden Name Fagie —
15. Birthplace Poland

16 (a) Informant Rose Davis (Wife)
(b) Address 3219 Woodland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-44 (month) (day) (year)
(c) Cemetery or crematory Pikesville Hebrew Memorial Park
Location Pikesville Md.
18 (a) Funeral director Jacob Davis Inc
(b) Address 1439 E. Balto. St

FEB 6 - 1944 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3-44 19 .. at 6 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1944 to 2/3 1944, and that I last saw him alive on 2/3 1944

Immediate cause of death Uraemia — 6 days
Due to Malignancy of prostate
Due to Carcinomatosis
Due to Bed sores, Malleable
Due to Pneumonia, terminal
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Krumen M. D.
Address — Date signed 2/4/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 13749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 13749 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Aged Home
(c) Hospital or institution: Lunacy & Relvedere

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Lewndale. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME BENJAMIN KOSTINSKY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Mitsa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER
12. Name Benjamin
13. Birthplace Russia
14. Maiden Name Fagis
15. Birthplace Russia

16 (a) Informant Harry
(b) Address 2914 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Pt. & Lemon Hill Rd
Location Lemon Hill Rd

18 (a) Funeral director Jack Levin Inc.
(b) Address 1439 E. Balto St

19 (a) FEB 6 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5 1944 at 2P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1943 to 2-5 1944 and that I last saw him alive on 2-5 1944.

Immediate cause of death: Chr. card. vascular lesions arteriosclerosis, Hypertension — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Levin
Address Lewndale Date signed 2/5/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13750

JL - 98276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136a

G 13750

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 S. Perrish St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Schaffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1869

8. AGE: Years	Months	Days	If less than one day
74 (75)	7	16	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Martin Schaffer
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Lowman
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7. 1944 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location City

18 (a) Funeral director Pott & Co. B. M. Walter
(b) Address Pratt & Sticks Sts

19 (a) Feb 6 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3 1944. at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1944. to 2-3 1944.
and that I last saw him alive on 2-3 1944.

Immediate cause of death

Uremia

Due to Urethral Stricture

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 days
yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald to Hebb

Address Balto City Hosp Date signed 2-3-44 M. D.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13751

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13751

Registered No. 1172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts.
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Waterview Ave., Westport Md.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME John W. Baggett, Sr.

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 213-01-8552

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Delma B.
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 1-23-1891

8. AGE: Years	Months	Days	If less than one day
53	0	13	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Defense work
11. Industry or business: Shipbuilding Equipment Corp

FATHER
12. Name: Samuel J Baggett
13. Birthplace: Washington D.C.

MOTHER
14. Maiden Name: Josephine Leightheardt (Leightheardt)
15. Birthplace: Balto Md

16 (a) Informant: Delma B. Baggett
(b) Address: 2812 Waterview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 9-1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: City

18 (a) Funeral director: Roll C & B. M. Walter
(b) Address: Pratt & Stricker Sts

19 (a) Date rec'd by (Registrar): 1944 Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5-1944, at 8:55 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3-1944 to 2-5-1944 and that I last saw him alive on 2-5-1944.

Immediate cause of death	Duration
Ruptured gastric ulcer with peritonitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Omar T. Bacon M. D.
Address Date signed

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

A 31522 G 13752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13752 / 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4830 Wright Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Jane Borlie

3 (b) If veteran, name war –

3 (c) Social Security Account No. ✓

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: –

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-43

8. AGE: Years | Months 8 9 | Days 24 | If less than one day hr min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stanley Borlie
13. Birthplace PA.

MOTHER
14. Maiden Name ANNA KRATZEN
15. Birthplace OKLA.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month, day, year)
(c) Cemetery or crematory Cartage Co.
Location

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw PLACE

FEB 6 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5-1944, at 10 29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1944 to Feb 5 1944 and that I last saw her alive on Feb 5 1944

Immediate cause of death Atelectasis

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 mo.
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaye, M.D.
Address 2401 Date signed 2/6/44

VS 150

G 13753

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13753 Registered No. 95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 728 N. Wolfe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 N. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David J. Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Estelle Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1885

8. AGE: Years	Months	Days	If less than one day
59	-	21	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation School Teacher
11. Industry or business

FATHER
12. Name Taylor Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Nannie Thompson
15. Birthplace Va.

16 (a) Informant Estelle Brown
(b) Address Midland Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 3, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Midland Va

18 (a) Funeral director Mrs. R. G. Elliott & Sons
(b) Address 1124 N. Carolina St

FEB 6 - 1944 (Date received by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1944 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1944 to Feb 4 1944, and that I last saw him alive on Feb 4 1944.

Immediate cause of death: Organic Heart Disease — Duration: Hours / Min

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. G. Gordon Elliott
Address 1534 Druid Hill Ave Date signed Feb 5 1944

G 13754 BALTIMORE CITY HEALTH DEPARTMENT G 13754
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5212 Tramore Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Tramore Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willa Glenn Noble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of husband or wife Louie Smith Noble

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15-1891

8. AGE: Years 52 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Hurlock Md.
(Town, county, and state)

10. Usual Occupation Supv. Balto Transfer Co.

11. Industry or business

FATHER
12. Name Twiford Wright Noble
13. Birthplace Hurlock Md

MOTHER
14. Maiden Name Lenora Mowbray Noble
15. Birthplace Dorchester Co., Md.

16 (a) Informant Louie Smith Noble
(b) Address 5212 Tramore Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Mash Ben's
Location Hurlock Md.

18 (a) Funeral director John A. Enoch
(b) Address 3009 E. Baltimore St
Transferred for Williams, Md.

FEB 6 - 1944
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Feb 4~~ 1944 ~~at 4~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1943 to 1/5 1944 and that I last saw h~~im~~ alive on 1/5 19 ~~44~~

Immediate cause of death Coronary Thrombosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Jones M. D.
Address 5703 Harford Rd Date signed 1/5/44

VS 3

PLEASE WRITE PLAINLY, with unfading ink. Every item on this certificate should be answered, or "unknown" where correct answer is not known. Physicians: please write the causes of death clearly and legibly.

G 13755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 191a

G 13755 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 E Melrose Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 E Melrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward H Burhorst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8 1906

8. AGE: Years	Months	Days	If less than one day
37	10	26	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Gardner Pointe Place

FATHER
12. Name Henry B. Burhorst
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Agatha Bishop
15. Birthplace Baltimore Md

16 (a) Informant Henry B. Burhorst
(b) Address 114 E Melrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Park
Location Baltimore Md

18 (a) Funeral director John C Mozan
(b) Address 3000 E Baltimore St

19 (a) 1944 (b) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 44 at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from February 4 1944 to February 4 1944, and that I last saw him alive on Feb 4 1944.

Immediate cause of death	Duration
Cerebral embolism	12 hours
Due to Subacute bacterial endocarditis	2 Mo.
Due to Congenital heart disease	Life
Other Conditions Cerebral embolism	1 Mo.

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Not
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work?
(e) Means of injury None

23. Signature A.L. Chalfant, M.D.
Address 6 216 York Road Date signed Feb 4 44

G 13756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G 13756 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N Rose St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Rose St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Joseph Mahon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1860

8. AGE: Years	Months	Days	If less than one day
63	6	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Gas Electric Co
11. Industry or business

FATHER
12. Name Martin Mahon
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose O'Hara
15. Birthplace Ireland

16 (a) Informant Teresa M. Mahon
(b) Address 110 N Rose St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John A Moran
(b) Address 3800 E Baltimore St

19 (a) [illegible] (b) Clayton Williams, M.D. (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3rd 1944 at 3:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1942 to Feb 7th 1944, and that I last saw him alive on Jan 27th 1944

Immediate cause of death Coronary Failure — Duration 2 yrs
Due to Coronary Thrombosis — 2.
Due to Hypertension
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Jenkins M. D.
Address 100 N. Mullen Date signed 2/4/44

G 13757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G 13757 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-5-29 Belair Road
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2537 Freemont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Virginia Haupt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 71 | Months — | Days — | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business Housewife

FATHER
12. Name Fred Ruff
13. Birthplace Baltimore

MOTHER
14. Maiden Name Isabel Scheeler
15. Birthplace Baltimore

16 (a) Informant Mrs Medinger
(b) Address 5-5-29 Belair Road

17 (a) Feb 7 - (Burial, cremation, or removal) (b) Date thereof 2 7 1944 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location —

18 (a) Funeral director Mary M Wiedefeld
(b) Address 301 E 32nd Sts

19 (a) Feb 6 1944 (b) Filed by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th. 1944. at 2:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24th. 1944 to Feb. 4th. 1944. and that I last saw her alive on Feb. 2nd. 1944.

Immediate cause of death	Duration
Coronary Occlusion	Immediate
Due to Endocarditis	unknown
Due to	
Other Conditions Myocarditis	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo W Morgan Jr M.D.

Address 401 E. 25th. St. Date signed 2/5/44.

G 13758

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164c

G 13758
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 859 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE TRUIETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jamie Truett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29 18[illegible]6

8. AGE: Years 47 | Months 5 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Garage man

11. Industry or business

FATHER
12. Name Jeremiah Truiett
13. Birthplace Md

MOTHER
14. Maiden Name Frances Hardman
15. Birthplace md.

16 (a) Informant Jamie Truett
(b) Address 859 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. PK.
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley Ave

19 (a) 1944 (Date received by registrar) (b) Huntington White [illegible]

FEB

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1944, at M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet wound of head

Due to Suicide

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-2-44 at 12:45 P.M. M.
(b) Where did injury occur? 859 Harlem Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Shot himself with pistol

23. Signature T. J. Wollenweber M.D.
Medical Examiner
Date signed 2-2-44

G 13759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 13759
Registered No.

100 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4510 Roland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4510 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Jeanette Ankers

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16 73

8. AGE: Years 70 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Chicago Ill. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Ill

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs M D Richmond
(b) Address 4510 Roland Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/6/44 (month) (day) (year)
(c) Cemetery or crematory Atlanta Ga
Location Atlanta Ga

18 (a) Funeral director Fullerton Co Inc
(b) Address 1214 Park Ave

FEB 7 - 1944 Date rec'd by local registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1944 at 330 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1944 to Feb 5 1944 and that I last saw her alive on Feb 4 1944

Immediate cause of death
Cerebral Thrombosis 2 days
Due to Cerebral Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1 yr
26 days

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H G Jones
Address 2818 N Charles Date signed 2/7/44

G 13760

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 33a

G 13760 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital (City)
(d) Length of stay in hospital or inst. (yrs., mos., or days) Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Delray Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Elaine Kron

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-1-43

8. AGE: Years | Months: 8 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Stephen J. Kron
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Effie de Gadau
15. Birthplace: Germany

16 (a) Informant: Stephen J. Kron
(b) Address: 1 Delray Ave - Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore - Md

18 (a) Funeral director: Edward Macnabb
(b) Address: Frederick & Wade Ave - Catonsville

19 (a) FEB 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1944 at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1944 to 2/4 1944 and that I last saw h-- alive on 2/4 1944.

Immediate cause of death: Bronchopneumonia — Duration: 4 days
Due to: Influenza — ?
Due to:
Other Conditions: Congenital Myxedema

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Sigmund Rapp M.D.
Address: Bon Secours Hospital Date signed 2/5/44

G 13761

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 B

Registered No. G 13761

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Wyman Park Driveway and 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 S. Smallwood Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROY DECATUR INSLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	242-14-6584	Male	White	Married

6 (b) Name of husband or wife Henrietta Posey
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 6/7/89

8. AGE: Years	Months	Days	If less than one day
54	7	28	hr. min.

9. Birthplace Wicomico County, Maryland
(Town, county, and state)
10. Usual Occupation Captain-Barge Ontario
11. Industry or business Seafaring

FATHER
12. Name John W. Insley
13. Birthplace Wicomico County, Maryland

MOTHER
14. Maiden Name Mary Elizabeth Robertson
15. Birthplace Wicomico County, Maryland

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8-1944 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Howard Co. Md.
18 (a) Funeral director George L. Schwab
(b) Address 2101 Eutaw Pl.
19 (a) FEB 7 1944 (b) Filed by Hunting Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1944 at 1:00 a.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8/44 19 to 2/5/44 19, and that I last saw him alive on 2/5/44 19

Immediate cause of death: Adenocarcinoma of stomach — Duration: 3 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature [signature]
Address US Marine Hospital, Baltimore, Md. Date signed 2/5/44 M. D.

3762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G 13762

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 114 W. 27th Street (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Avery Locke Robbins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1944

8. AGE: Years	Months	Days	If less than one day
—	—	12	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

MOTHER / FATHER

12. Name William Lee Robbins

13. Birthplace North Carolina

14. Maiden Name Bertha Ditto

15. Birthplace Pennsylvania

16 (a) Informant Wm Lee Robbins

(b) Address 114 W. 27th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location R. C. Co. Md.

18 (a) Funeral director William Cook Sons

(b) Address 1217 E. Pratt St. Huntington Williams, Jr. M.D.

19 (a) 1944 (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1944, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3, 1944, to Feb. 5 1944, and that I last saw him alive on Feb. 5 1944.

Immediate cause of death ~~Acidosis~~ Respiratory Failure — Duration

Due to Intracranial Hemorrhage

Due to

Other Conditions Dehydration & Acidosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. E. Hasenbusch M. D.

Address Mercy Hospital Date signed 2/5/44

13763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

156 G 13763 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. If unknown, write "unknown." Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Wilkmott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Lee BURNEY, JR

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) March 13th June 1942

8. AGE: Years	Months	Days	If less than one day
1	1	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Carl Lee Burney
13. Birthplace Florida

MOTHER
14. Maiden Name Amy E. Baughan
15. Birthplace Charlesville Md.

16 (a) Informant Mrs Carl Burney
(b) Address 922 Wilmot Court

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 2 7 44 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 27 St. Paul St

19 (a) Received by Registrar Feb 7 1944 (b) Filed by Registrar Feb 8 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1944, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Feb 5 1944, and that I last saw him alive on Feb 5, 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Pseudohypertrophic muscular dystrophy	7 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Murray Wenner, M.D.
Address Sinai Hospital Date signed 2/5

13764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13764
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
2145 Kirk Ave 1-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph T. Brunner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31st 1889

8. AGE: Years	Months	Days	If less than one day
54	0	5	hr. min.

9. Birthplace Reisterstown, Md.
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Unknown

FATHER
12. Name Joseph T. Brunner
13. Birthplace Reisterstown, Md.

MOTHER
14. Maiden Name Sarah Krueger
15. Birthplace Reisterstown Md.

16 (a) Informant Margaret E. Cousler
(b) Address 31 S. Kremon St.

17 (a) Burial (b) Date thereof 2/8/44
(Burial, ~~cremation or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Reisterstown Md

18 (a) Funeral director Wilkins Cook Inc.
(b) Address 1243 St. Paul st

19 (a) FEB 7 - 1944 Clinton Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1944, at 1014 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 5, 1944

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. G 13765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 W. Lexington St.
(c) Hospital or institution: Volunteers of America
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 W. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES A. GALE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, ~~married~~, ~~widowed~~, or ~~divorced~~
M	W	Married

6 (b) Name of husband or wife Augusta
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May. 10 - 1878

8. AGE: Years	Months	Days	If less than one day
65	8	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER	12. Name James A. Gale
	13. Birthplace Kent Co.
MOTHER	14. Maiden Name Julia Skedden
	15. Birthplace Dorchester Co.

16 (a) Informant Mrs. Mayo
(b) Address 3204 Parkview

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7 1944 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Hampden
Location Baltimore Md.

18 (a) Funeral director Mc Cord Sons
(b) Address Paul & Preston

19 FEB 7 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1944, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1944, to Feb 5 1944, and that I last saw him alive on Feb 5 1944.

Immediate cause of death	Duration
Hemorrhage from Peptic ulcer -	
Due to Arteriosclerotic CVND	
Due to Congestive Heart failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Willard Applefeld M. D.
Address 2511 Reisterstown Rd Date signed

VS 1

Correct age is especially important. Physician: please write out words as well as figures and supply omissions.

G 13766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 13766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 E. Eager St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 E. Eager St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Helen E. Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Townsend Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April , 1864

8. AGE: Years 79 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Georgetown, D. C. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Henry C. Evans
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Mary E. Garretson
15. Birthplace Baltimore, Md.

16 (a) Informant Townsend Scott
(b) Address Cockeysville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (Date received by registrar) FEB 7 - 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1944 at 2:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Feb 4 1944, and that I last saw her alive on Feb 3 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 2-3 hrs.
Due to: Arteriosclerosis — Myocarditis — Gradual
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. W. Peabody
Address 1403 Park Ave. Date signed 2/7/44 (M D)

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 13767 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 Myrtle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Athlea R. Bradford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Frank Bradford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1893

8. AGE: Years	Months	Days	If less than one day
50	5	5	hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name Arthur Tomlin
13. Birthplace Va.

MOTHER
14. Maiden Name Nannie Pitts
15. Birthplace Va.

16 (a) Informant Mr. Frank Bradford
(b) Address 1102 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Town
Location Baltimore, Md.
18 (a) Funeral director Jesper W. Redclew
(b) Address 430 W. Baltimore St.
19 FEB 7 - 1944 (Date rec'd by registrar) Lamington Williams Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 4, '44 19 at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1943, to Feb 4 1944, and that I last saw h-r alive on Feb 4 1944.

Immediate cause of death Acute Cardiac dilatation — Duration

Due to Hypertension and anaemia.

Due to

Other Conditions Hyperanemia from bronchio-pneumonia

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. B. French M D
Address 2379 Arunah Date signed 2/7/44

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 13768

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1231 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie E. Dorsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Edwin H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28, 1881

8. AGE: Years	Months	Days	If less than one day
62	2	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank W. Gaither
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza A. Barber
15. Birthplace Md

16 (a) Informant Mr. Edwin H. Dorsey
(b) Address 1231 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Harmony
Location Cookesville Md.

18 (a) Funeral director Harry A. Wilkes
(b) Address 401 Edmondson Ave.

19 (a) FEB 7 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1944, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1943 to Feb 4 1944.
and that I last saw h.e alive on Feb 2 1944.

	Duration
Immediate cause of death: Coronary Thrombosis	Suddenly
Due to: Cardio-Vascular Renal & Hypertension	7 Years
Due to:	
Other Conditions: Asthma Bronchial (Include pregnancy within 3 months of death)	8 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott W. Johnson M. D.
Address 2432 Madison Ave. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13769 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3410 DOLFIELD BLVD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11 11
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 DOLFIELD BLVD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA EPSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife JAMES

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace RIGA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name URIEL *
13. Birthplace RIGA

MOTHER
14. Maiden Name MOLLIE
15. Birthplace RIGA

16 (a) Informant URIEL EPSTEIN - SON
(b) Address 3410 DOLFIELD BLVD

17 (a) BORIAL (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO. T CONKLIN STS.

18 (a) Funeral director JACK LEWIS INC
(b) Address 1437 E. BALTO. ST

19 (a) FEB 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5-44 19 at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1918. to Feby 5 1944. and that I last saw h er alive on Feby 5 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 1 day

Due to Arteriosclerosis and Hypertension — 25 yrs.

Due to Diabetes mellitus — 25 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Pl. Date signed 2-6-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G 13770 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2417 BROOKFIELD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 3 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 BROOKFIELD AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM SHEAR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOW

6 (b) Name of husband or wife KATIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1878

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name LOUIS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant SAM SHEAR
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO T CONKLIN SRS

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (a) FEB 7 1944 (Date rec'd by Registrar) Burington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1943 to 2/6 1944.
and that I last saw him alive on 2/6 1944.

Immediate cause of death	Duration
a. Pulmonary edema	24 hrs
Due to Cerebral arteriosclerosis	1 yr
Due to Myocardial insufficiency	14 mos
Other Conditions Cerebral hemorrhage	2½ mos

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Lemmon M. D.
Address 4004 Liberty Hgts Ave Date signed 2/6/44

VS 150

G 13771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13771 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville Wilkins Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Eggs Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Blanche Thompson

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ira Eugene Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1899

8. AGE: Years 44 Months 6 Days 28 If less than one day hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Wiles
13. Birthplace Frederick Co. Md

MOTHER
14. Maiden Name Sarah Rebecca Castle
15. Birthplace Frederick Co. Md.

16 (a) Informant Ira E. Thompson
(b) Address 17 Eggs Lane Cat 2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7, 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City Md

19 (Date received by registrar) FEB 7 - 1944 Funeral for Williams M.P.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 3 1944 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1944 to 2-3 1944 and that I last saw her alive on 2-3 1944

Immediate cause of death Hypertensive Cardio-Vascular Disease — Duration 2 mos.

Due to

Due to

Other Conditions Cerebral hemorrhage — 3 hours
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Burgtorf M. D.
Address Ellicott City, Md. Date signed 2-6-44

VS 8

13772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13772
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Cuslowen Rd
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Cuslowen Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank R Espey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Elma Espey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 19th - 1894

8. AGE: Years	Months	Days	If less than one day
49	1	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business A & P Store

FATHER
12. Name William Espey
13. Birthplace Howard Co Md

MOTHER
14. Maiden Name Sarah Fisher
15. Birthplace Howard Co Md

16 (a) Informant Elma Espey
(b) Address 1009 Cuslowen Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Charles P Towell
(b) Address 2427 Edmondson Ave

19 (a) FEB 7 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1944 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1944 to 2/5 1944 and that I last saw him alive on 2/5 1944

Immediate cause of death: Cerebral Embolism — Duration 5 hrs.
Due to: Myocardial degeneration — 2 wks.
Due to:
Other Conditions: Spontaneous pneumothorax (L)
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Seymour Rosen, M.D.
Address Bon Secours Hospital 2/5/44 (Date signed)

VS 3

13773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 13773
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4411 Atwick Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write Rural and give town)
(d) Street No. 4411 Atwick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Frank H. Mackin.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married.

6 (b) Name of husband or wife Myrtle A. Mackin
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1892

8. AGE: Years	Months	Days	If less than one day
52 51	-	11	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Physician.

FATHER
12. Name Joseph Mackin.
13. Birthplace Maryland

MOTHER
14. Maiden Name Effie Price.
15. Birthplace Maryland

16 (a) Informant Myrtle A. Mackin
(b) Address 4411 Atwick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3465 Chestnut Ave

19 FEB 7 - 1944 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1944 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 3 1944 and that I last saw h alive on Feb 2 1944.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw. H. Hassmann M. D.
Address 4037 Fodd Rd Date signed 2/7/44

VS 180

COPIES MUST BE MADE FROM THIS RECORD. ANY ALTERATIONS OR ERASURES VOID THIS CERTIFICATE. PENALTY FOR MAKING FALSE STATEMENTS.

13774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G 13774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD STERLING

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1882

8. AGE: Years	Months	Days	If less than one day
61	7	26	25 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Blacksmith

11. Industry or business unemployed.

FATHER
12. Name Charles Stirling
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Englehart
15. Birthplace Md.

16 (a) Informant Mrs. Rose Jones (Sister)
(b) Address 324 S. Hawkins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 9 44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto. Co. Md.

18 (a) Funeral director Wm Cook Jay.
(b) Address 1217 St. Paul St.

19 (a) FEB 7 - 1944 (Date rec'd by registrar) Huntington Williams, Jr. Registrar

VR 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1944 at 11 55 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. (Medical Examiner.)

Date signed 2-6-44

3775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13775
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6226 Carbone Way
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE W. RITTENBERRY

3 (b) If veteran, name war —

3 (c) Social Security Account No. — --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	white	widowed

6 (b) Name of husband or wife John B

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1879

8. AGE: Years	Months	Days	If less than one day
64	9	14	hr min

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Aaron Grace
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Kimble
15. Birthplace Md

16 (a) Informant Mrs. Grace Sullivan
(b) Address 6226 Carbone Way O'Donnell Hghts.

17 (a) Burial (b) Date thereof 2 9 94
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park
Location Balto, Md.

18 (a) Funeral director Wm Cook, Inc
(b) Address 1212 St. Paul St.

19 (a) FEB 7 - 1944 (b) Huntington Williams, Mgr.
(Date rec'd by registrar) Registrar

VS 15t

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5th 19 44 at 2 45 PM

21. I certify that I took charge of the remains described above, held an inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cerebrovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmaier M.D.
Asst Medical Examiner.
Date signed 2-6-44

G 13776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13776 ✓ Registered No. 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 351 S. Mount St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 44
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 351 S. Mount St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles Henry Ernest

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Rosina Ernest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1861

8. AGE: Years	Months	Days	If less than one day
82	1	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Telegraph Operator
11. Industry or business Penna. R.R. Retired

FATHER
12. Name Daniel Ernest
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Grunewald
15. Birthplace Germany

16 (a) Informant Mr Charles H. Ernest
(b) Address 351 S. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick H. Coles
(b) Address 1200 W. Lombard St

19 (a) Date received FEB 7 1944 (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1944, at 4 10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles P. Lubrano M.D. Medical Examiner.
Date signed 2/3/44

6777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G 13777

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3119 Berkshire
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Berkshire (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HANNAH ALMIRA MELBOURNE

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Dr. John W. Melbourne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1859

8. AGE: Years	Months	Days	If less than one day
84	1	15	..... hr. ..... min.

9. Birthplace New York, N. Y. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Louis James Westcott
13. Birthplace Conn.

MOTHER
14. Maiden Name Hope Carporter
15. Birthplace Conn.

16 (a) Informant Mrs. Harold Binns
(b) Address 3119 Berkshire Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by registrar FEB 7 - 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18-1938 to 2-6-1944, and that I last saw her alive on 2-4-1944.

Immediate cause of death: Arteriosclerotic cardio-renal disease (Duration: 6 years)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Lybert M. D.
Address 2402 Harford Rd. Date signed 2-7-44

3778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 82

G 13778
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Appleton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Appleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BETTY MARGARET RILEY

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1928

8. AGE: Years	Months	Days	If less than one day
15	9	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James C. Riley
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Furst
15. Birthplace Baltimore

16 (a) Informant Mrs. Margaret Riley
(b) Address 822 N. Appleton St.

17 (a) Burial (b) Date thereof 2/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 7 - 1944 (b) Huntington Williams, Mort.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1944, at 6.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Feb 4 1944.
and that I last saw her alive on Feb 4 1944

Immediate cause of death Bronchopneumonia — Duration 3 days
Due to Syringomyelia — 10 years
Due to
Other Conditions Pyelocystitis — 4 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lawson Wilkins M. D.
Address 1014 St Paul St Date signed Feb 5, 1944

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Please state correct age in each case, especially important.

8

3779

BALTIMORE CITY HEALTH DEPARTMENT

✓ G 13779
Registered No.

13779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 13779
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Paula Read (Margaretta Paula Read)

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Lindley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1868

8. AGE: Years 75 | Months 3 | Days 29 | If less than one day: hr. min.

9. Birthplace: Austria
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: -- Jans
13. Birthplace: Austria

MOTHER
14. Maiden Name: unknown
15. Birthplace: "

16 (a) Informant: Mrs. Walter S. Read
(b) Address: 304 St. Dunstans Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

FEB 7 - 1944
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1944, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed February 5 1944

VS 151

13780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G 13780
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oldtown Willard Ave.
(c) Hospital or institution: St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Christian St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgianna Elizabeth East

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9th 1943

8. AGE: Years	Months	Days	If less than one day
	9	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis B. East
13. Birthplace Balto Md

MOTHER
14. Maiden Name Evelyn T. Emery
15. Birthplace Balto Md

16 (a) Informant Louis B East
(b) Address 1930 Christian st

17 (a) (Burial, cremation, or removal) (b) Date thereof 2nd 7th 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location

18 (a) Funeral director A. Jones
(b) Address 111 S. Gilmor st

FEB 7 — 1944 (Date filed by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1944 at 6 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1944 to 2/4 1944, and that I last saw her alive on 2/4 1944.

Immediate cause of death Acute Mesenteric Lymphadenitis

Due to

Due to

Other Conditions Congenital Malformation of Heart

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur Loomis
Address St. Agnes Hosp. Date signed 2/4/44

Please answer all questions. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

13781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13781
Registered No.

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1825 Dover st
(c) Hospital or institution:
Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Dover St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine or Victoria Collins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Joseph Christie
13. Birthplace Balto Md

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Anna Jones
(b) Address 111 S. Gilmor St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 2nd 7th 44

(c) Cemetery or crematory Mt Olivet Cem
Location

18 (a) Funeral director A. Jones
(b) Address 111 S. Gilmor st

19 (a) FEB 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1944, at 1.45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 4 1944

44823S

13782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13782
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6120 Alta Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Burkhardt DORIS M. BURKHARDT

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-12-14

8. AGE: Years 29 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Charles Roth

13. Birthplace Md.

MOTHER

14. Maiden Name Stella Truelove

15. Birthplace Maryland

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9th 1943 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Parkville, Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Road

19 (a) Date received by local registrar FEB 7 1944 (b) H. Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1944 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1944 to 2/5 1944 and that I last saw her alive on 2/5 1944.

Immediate cause of death: Cardiac Failure — Duration 1 day

Due to Hypertensive Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. H. Huntington Williams M. D.

Address Johns Hopkins Date signed 2/6/44

Physicians: please write the causes of death clearly and legibly. Accuracy in correct age is especially important.

3783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 13783
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville
(c) Hospital or institution: Fenhaven Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 months
(e) Length of stay in Baltimore (yrs., mos., or days) 81 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Wickford Road
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Mr. William B. Booz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, (widowed) or divorced: Widowed

6 (b) Name of husband or wife: Hannah Ferguson

6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.): Dec. 28, 1862

8. AGE: Years 81 | Months 1 | Days 8 | If less than one day: --hr. ---min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business: -----

FATHER
12. Name: Charles W. Booz
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Harriet Shinnick
15. Birthplace: Baltimore, Maryland

16 (a) Informant: E. Webster Bartholow
(b) Address: 4208 Wickford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Means & Son
(b) Address: 805 N. Calvert Street

19 FEB 7 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Febr. 6 1944, at 2 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1943, to Feb. 6 1944, and that I last saw h[illegible] alive on Feb. 6 1944.

Immediate cause of death	Duration
Arteriosclerotic C-V-D	
Due to	
Due to	
Other Conditions Hemiplegia, Rt.	95 Mos.

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: C. Arthur Rossberg

Address St. Agnes Hosp. Date signed 2/6/44

VS 180

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 c

Registered No. G 13784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Sharp Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie E Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Levi Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1877

8. AGE: Years 66 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation
11. Industry or business at Home

FATHER 12. Name Robert Maddox
13. Birthplace Md

MOTHER 14. Maiden Name Harriett —
15. Birthplace Md

16 (a) Informant Levi Jackson
(b) Address 824 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Fiel St

FEB 7 - 1944 Date rec'd by registrar — Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1944, at 8:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Hers death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple fractures of ribs, left; atelectasis of lung, left

Fracture of left leg.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 2 at 2/1944 8 55 P M
(b) Where did injury occur? Corner of Hanover & Hill Sts
(c) Did injury occur at home, on farm, industrial place, in public place? street While at work? No
(d) Means of injury Struck by auto

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed February 5, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 13785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92a

Registered No. C 13785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Fred. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 560 Orchard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Williams died

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married —
6 (b) Name of husband or wife: Joseph Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 60 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Balto. Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Dan Hollen
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Yorkstown
15. Birthplace:

16 (a) Informant: Joseph Williams
(b) Address: 560 Orchard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 7 1944 (month) (day) (year)
(c) Cemetery or crematory: Laurel Cem.
Location

18 (a) Funeral director: Mrs Katie P Williams
(b) Address: 322 N. Bond St.

19 (a) FEB 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 - 3 - 1944, at 8 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Rheumatic Endocarditis — Aortic + Mitral Valves

Due to

Other Conditions: Arteriosclerosis of both. Generalized arteriosclerosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Mendeloff M.D.
Medical Examiner.
Date signed 2-4-44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13786

448097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 E

Registered No.

G 13786

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vernon Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-30-09

8. AGE: Years 34 | Months 2 | Days 4 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Hotel Worker

11. Industry or business

MOTHER / FATHER

12. Name Ernest Scott

13. Birthplace Md

14. Maiden Name Lilly Carroll

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

FEB 7 1944 (Date Rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

8

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1944, at 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944 to Feb 4 1944, and that I last saw h[illegible] alive on Feb 4 1944

Immediate cause of death: Respiratory failure + convulsions (Uraemia) — Duration: 4-5 days

Due to: Metastatic mediastinal lymph node enlargement. — Duration: 4-5 months

Due to: Mucinous forming adeno carcinoma of transverse colon. — Duration: 6 months

Other Conditions: Anemia, hypoprothrombinemia, Biopsy supraclavicular node. (Include pregnancy within 3 months of death)

Date of operation: 12-29-43

Major findings of operation: Metastatic mucinous forming adenocarcinoma.

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Abraham Gardner

Address J. Hopkins Date signed Feb 7 1944

G 13787 G 13787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H HILL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1895

8. AGE: Years 48 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name

13. Birthplace Unknown

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Irene Hill

(b) Address 1142 Argyle Avenue

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-9-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore MD

18 (a) Funeral director William A Jackson

(b) Address 916 Penna ave

19 (a) FEB 7 1944 (Date rec'd by Registrar) (b) Registrar, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6th 1944, at 4:50 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH

Paralysis, Spinal

Due to Contusion of head and back

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2-5-44 at 11:45 P M.

(b) Where did injury occur? 92 Park Ave

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury fall against radiator

23. Signature H. L. Wallenmeyer M.D. Asst Medical Examiner.

Date signed 2-6-44

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

G 13788 Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fremont & Green Sts.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2297 Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Last) Levi Conquest.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	Negro.	Married

6 (b) Name of husband or wife Bettie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 10, 1881

8. AGE: Years	Months	Days	If less than one day
62	9	26	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Levi Conquest
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Bettie Conquest
(b) Address 2297 N Ann St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem. Location A. A. County Md.
18 (a) Funeral director Wm. Robert A. Elliott Jr.
(b) Address 1129 N. Carlton St.
19 (a) Date received FEB 7 1944 (Registrar) (b) Filed Feb 10 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944, at 7 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1944 to Feb 6 1944, and that I last saw him alive on Feb 5 1944.

Immediate cause of death Hemorrhage into spinal Canal — Duration
Due to
Due to
Other Conditions Tuberculosis Pulmonary Advanced Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Wilbur J. Laverne M.D.
Address Provident Hospital Date signed 2/6/44

G 13789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3412 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3412 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Blake Johnston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/26/1842

8. AGE: Years 51 Months 11 Days 9 10 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Civil Engr.

11. Industry or business Engineering

FATHER
12. Name Wm L. Johnston
13. Birthplace Md

MOTHER
14. Maiden Name Mary Marriott
15. Birthplace Md

16 (a) Informant Miss E. Johnston
(b) Address 3412 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/1944 (month) (day) (year)

(c) Cemetery or crematory Loudenon
Location Balto Co Md

18 (a) Funeral director J. J. Tobey & Sons
(b) Address 1218 Light St

19 FEB 7 — 1944 (Date R'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5th 1944, at 70 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to Feb 5th 1944 and that I last saw him alive on Feb 5th 1944.

Immediate cause of death Prostatic + Suprarenal Carcinoma — Duration 1 Yr Mos

Due to Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno E. Whitehill M. D.
Address 230 E. Univ Pkwy Date signed 2/7/1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G 13790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. G 13790

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 N. Pulaski
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N. Pulaski
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph H. Gallagher

3 (b) If veteran, name war Spanish-American

3 (c) Social Security Account No. 217-03-7819

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Blanche H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25, 1862

8. AGE: Years 71 | Months 2 | Days 11/12 | If less than one day hr. min.

9. Birthplace Md.
(City or county, and state)

10. Usual Occupation Plumber

11. Industry or business Retired

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Blanche Gallagher
(b) Address 501 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 9 44 (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Balto.

18 (a) Funeral director Wm Cook, Inc
(b) Address 1217 St. Paul St

19 (a) 2-7-1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7- 1944, at 1:20 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Chronic Tuberculous Peritonitis

Due to

Other Conditions Chronic Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masters M.D.
Medical Examiner.
Date signed 2-7-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 13791 G 13791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/21a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2741 Guilford avenue
(c) Hospital or institution: ------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 10 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2741 Guilford avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA HUETCHER

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife Michael Huetcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1871

8. AGE: Years	Months	Days	If less than one day
73	--	16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Harry A. Huetcher
(b) Address 2741 Guilford avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 7, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Cincinnati Ohio

18 (a) Funeral director Chas. J. Eggan & Son Inc
(b) Address 118 N. Mt. Royal Ave

Feb 7 1944 (b) ---
(Date rec'd by registrar) Registrar

Planting for Hillcrest, Mar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1943 to Feb 5 1944, and that I last saw h[er] alive on Jan 17 1944

Immediate cause of death: Hypertension & Vascular disease of heart — Duration: Instant

Due to arterio sclerosis & chronic nephritis — years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. J. Emmert M. D.
Address Medical arts Bldg Date signed

Please write plainly. Physicians: please write the causes of death clearly and legibly. Each question is important.

G 13792 G 13792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 150 N. Kenwood avenue
(c) Hospital or institution: --------
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County - -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 150 N. Kenwood avenue (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES R. McLEAN

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White.	Widow

6 (b) Name of husband or wife Allan C. McLean
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1875

8. AGE: Years	Months	Days	If less than one day
68	3	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Thomas P. Raftery
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Flanagan
15. Birthplace Ireland

16 (a) Informant Mrs. Mary F. Dorsey
(b) Address 3023 Harlem avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick road

18 (a) Funeral director Chas. P. Cooper Son Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) FEB 7 1944 (Date rec'd by city registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1944, at 70. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1939 to Feb 4 1944
and that I last saw her alive on Jan 29 1944

Immediate cause of death

Duration

Coronary Occlusion

Due to

Due to

Other Conditions -

(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operations: -

of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - While at work? - (Specify type of place)
(e) Means of injury

23. Signature Odelia A. Cullen
Address 12 19 Poplar Grove Date signed 2/5/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13793
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 Shields Place
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 27 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore C.T.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Shields Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Joseph K. Lee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1	2	9	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name Joseph Lee
13. Birthplace md

MOTHER
14. Maiden Name Ruth Johnson
15. Birthplace md

16 (a) Informant Ruth Lee
(b) Address 908 Shields Pl

17 (a) Burial (b) Date thereof 2/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 7 - 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1944, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Marasmus
Rickets

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles J. Lubinski M.D.
Medical Examiner.
Date signed 2/6/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 13794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92c

G 13794
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Guilford & 30th St.
(c) Hospital or institution:
Woodrow Apartments
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. 30th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilber Bender

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva Bender

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1902

8. AGE: Years 41 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Horace Bender
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Reynolds
15. Birthplace Maryland

16 (a) Informant Eva Bender
(b) Address 300 E 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Md

18 (a) Funeral director Geo. H. Kelbaugh
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 7 1944 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1944 at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Valvular heart disease, aortic stenosis, rheumatic fever

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Harry L. Mollenhauer M.D.
Medical Examiner.
Date signed 2-7-44
Geo. Howard Wallis M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 13795 T.N (85688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13795 Registered No. 56B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maude Grant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Color	Widow

6 (b) Name of husband or wife Joseph (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 1901

8. AGE: Years	Months	Days	If less than one day
42	9 ?	28?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Washington (D
13. Birthplace Va.

MOTHER
14. Maiden Name Marie Stewart (D
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn, Location Md

18 (a) Funeral director George H. Kilson
(b) Address 1103 Brentman St

FEB 7 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4 1944, at 3:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1943 to 2-4 1944, and that I last saw h[illegible] alive on 2-4 1944.

Immediate cause of death	Duration Immediate
Hypertensive Encephalopathy	
Due to Hypertensive C-V Disease	7
Due to	
Other Conditions Gangrene L Arm, Uterine Fibroids	?

(Include pregnancy within 3 months of death)
Date of operation 12-24-43; 1-22-44
Major findings of operation: Gangrene Arm, Uterine Fibroids
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald B. Hurt M. D.
Address Balto City Hosp Date signed 2-4-44

G 13796

G 13796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reyser & Dukeland
(c) Hospital or institution: West Balt. Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Russel Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MERKER N. BUPPERT (Merker N. Buppert)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-1507

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine Buppert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1885

8. AGE: Years	Months	Days	If less than one day
58 ~~60~~	10	4	hr. min.

9. Birthplace Hebbville, Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Lewis Buppert
13. Birthplace Hebbville, Baltimore Co., Md.

MOTHER
14. Maiden Name Margaret Subock
15. Birthplace Hebbville, Baltimore Co., Md.

16 (a) Informant Mrs. Merker N. Buppert
(b) Address 2012 Russell Ave., Woodlawn, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 4510 Liberty Heights Ave.

19 (a) 1944 (b) Clinton Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6/44 19 at 5.55A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/28/44 19 to 2/6/44 19, and that I last saw him alive on 2/6/44 19

Immediate cause of death	Duration
Toxemia	
Due to Arteriosel. CVD	
Due to	
Other Conditions Gangrene - left leg & foot	

(Include pregnancy within 3 months of death)

Date of operation 2/6/44

Major findings of operation: Arteriosel CVD Gangrene

of autopsy: Left foot & leg

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. N. Friedman M.D.
Address WBGH Date signed 2/7/44

VS 180

Print age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 937

G 13797 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 month

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Clark County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Stimmel (George W. Stimmel)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1880

8. AGE: Years	Months	Days	If less than one day
63	9	5	hr. min.

9. Birthplace Frederick County, Va. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Self

FATHER
12. Name George W. Stimmel
13. Birthplace Virginia

MOTHER
14. Maiden Name Artimitia Sherman
15. Birthplace Virginia

16 (a) Informant Mrs. Laura V. Yeakley
(b) Address Clark County, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Hebron Cemetery
Location Winchester, Va.

18 (a) Funeral Director Miles Lawrason
(b) Address 4510 Liberty Heights Ave.

19 (a) FEB 10 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5 1944 at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1944 to 2-5 1944, and that I last saw h/M alive on 2-4 1944

Immediate cause of death: Congestive Heart Failure — Duration: 5 days
Due to Hypertension C-V Disease
Due to
Other Conditions Prostatic.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Vogel Jr. M. D.
Address Box Seamn Hosp. Date signed 2-5-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

13798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/13B

Registered No. G 13798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Homewood Hospital 4N
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Savage
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. Camp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Perry Edwards

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 7 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 7 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4- 1944, at 5-55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Acute Miliary Tuberculosis of Lungs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malpas M.D.
Medical Examiner.
Date signed 1-5-44

0715

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13799

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1830

Registered No. G 13799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Brune Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE GOULD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 7 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) FEB 7 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1944, at 8:45 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenmann M.D.
Medical Examiner.
Date signed

0716

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13800 A 20984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13800 Registered No.

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 E ~~Eagle~~ Eager (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-8-1940

8. AGE: Years	Months	Days	If less than one day
4	-	28	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ruben Boyd
13. Birthplace Va

MOTHER
14. Maiden Name Allie Mae Henrick
15. Birthplace Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Cooper
(b) Address 1624 N. Carlisle Ave.

19 (a) FEB 7 - 1944 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 19 44 at 1 ~~45~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: subdural hygroma — Duration 10 d.
Due to: Head injury
Due to: accidental fall
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Jan. 25, 1944 at M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fell down stairs

23. Signature Robert Lane
Address J H H Date signed 2/7/44

VS 260

G 13801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G 13801 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: Saint Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 Eden St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B. Dess

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-09-9364

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Susan Schwarzkopf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15, 1861

8. AGE: Years 82 | Months 3 | Days 22 | If less than one day ##### hrs. ##### min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Cabinet Maker

11. Industry or business

FATHER
12. Name Francis X. Dess
13. Birthplace Germany

MOTHER
14. Maiden Name Rose Trenberger
15. Birthplace Germany

16 (a) Informant William H. Dess, Sr.
(b) Address 3110 Cliftmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Balto. Md

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Ave.

19 (a) FEB 7 - 1944 (Date rec'd by registrar) (b) Huntington Witness, M.D.

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1944 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28-44 1944 to 2-6 1944, and that I last saw him alive on 2-6 1944.

Immediate cause of death: Arteriosclerotic cardio-vascular disease with myocardial failure — Duration: 3 wks.

Due to

Due to

Other Conditions: Carcinoma of gall-bladder, liver and pancreas (Include pregnancy within 3 months of death)

Date of operation 1-31-44

Major findings of operation: Carcinoma of gall bladder, liver and pancreas

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz, M.D.
Address St. Joseph's Hosp. Date signed 2-8-44

correct age is especially important. Physicians: please write the causes of death very plainly.

G 13802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 13802 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2832 Watermen Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2832 Waterman (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey H Hamrick

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Minnie Hamrick
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) April 30 1877

8. AGE: Years	Months	Days	less than one day
68	9	6	hr. min.

9. Birthplace Del (Town, county, and state)
10. Usual Occupation Veneer Works
11. Industry or business

FATHER 12. Name Henry Hamrick
13. Birthplace

MOTHER 14. Maiden Name Mary Huffman
15. Birthplace Del

16 (a) Informant Minnie Hamrick
(b) Address 2832 Waterman Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 7/44 (month) (day) (year)
(c) Cemetery or crematory Careys Cem
Location Sussex Co Del

18 (a) Funeral director C E Watson
(b) Address Frankford Del

19 (a) Feb 7 1944 (b) Harrington Williams M.D. by registrar Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1944 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Feb 6 1944, and that I last saw h[illegible] alive on Feb 6 1944.

Immediate cause of death: Cardiac Failure — Duration: 1 week
Due to
Due to Arteriosclerotic C. V. D.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Satterfield
Address 2321 Arnold Ave Date signed 2/6/44 M. D.

Street address is especially important. Physicians: please write the causes of death clearly and legibly.

G 13803 G 13803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1 X 937

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: South Balto. Gen. Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County .....
(c) City or town Pottsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Sarah Evans

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm. Evans.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1875

8. AGE: Years	Months	Days	If less than one day
68	4	15	..... hr. ..... min.

9. Birthplace Wales
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Howell
13. Birthplace Wales

MOTHER
14. Maiden Name —
15. Birthplace Wales

16 (a) Informant Randolph Auer
(b) Address 708 Seneca St Pottsville Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Laurel
Location Minersville Pa.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Tulpehocken St

19 (a) 2-8-44 Washington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7-1944, at 5 05 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH .....

Chronic Myocardial Degeneration

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Medders M.D.
Medical Examiner.
Date signed 2-7-44

VS 151

G 13804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13804
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 Hanover St.
(If rural give location)
(e) Citizen of foreign country? Hanover (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Shapporal

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-3313

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Frances Shapporal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Steamfitter
11. Industry or business

FATHER
12. Name Louis Shapporal
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant Frances Shapporal
(b) Address 1435 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Orazowski
(b) Address 1930 Eastern Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1944, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratton M.D.
Medical Examiner.
Date signed Feb. 5, 1944

MD 151 1944

G 13805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 Marista Ave. Inverness
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Inverness
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Marista Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET HOLCOMB

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1932

8. AGE: Years 11 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Williamsport Pa.
(town, county, and state)

10. Usual Occupation Schoolgirl

11. Industry or business

FATHER
12. Name Allyn Holcomb
13. Birthplace W. Va.

MOTHER
14. Maiden Name Regina Leonard
15. Birthplace Pa.

16 (a) Informant Parents
(b) Address 7 Marista Ave. Inverness

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8-1944 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Bengies Mill Rd.

18 (a) Funeral director John G. Connolly
(b) Address 4 E Eastern Blvd.

19 (a) 1944 (Filed by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4, 1944 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1943 to Jan 1, 1944 and that I last saw h[illegible] alive on Jan, 1944

Immediate cause of death	Duration
Respiratory Paralysis	
Due to Poliomyelitis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Murray Sanner M. D.
Address Sinai Hosp. Date signed 2/4/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 250

13806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 13806 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1634 Carswell St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Carswell St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patrick Joseph Finnegan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Margaret Finnegan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March-17-1857

8. AGE: Years	Months	Days	If less than one day
86	10	19	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Owen Finnegan
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Leo Finnegan
(b) Address 2329 E. South St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-8-44 (month) (day) (year)
(c) Cemetery or crematory Mary's Cathedral
Location Baltimore, Md.

18 (a) Funeral director John E. Melly Son
(b) Address 2425 E. Oliver St

19 (a) Date received FEB 8 1944 Harrington-Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5-1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 5 1944, and that I last saw [deceased] alive on Feb 5 1944.

Immediate cause of death: Myocardial Infarction
Due to: Age
Due to: —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration: 5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Geo L Zimmerman M. D.
Address 9958 Harford Rd Date signed 2/7/44

Street age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13807 Registered No. 83B

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Desoto Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 De Soto Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dawn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Frances Dawn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 20 1877

8. AGE: Years	Months	Days	If less than one day
66	9	16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER 12. Name John Dawn
13. Birthplace Germany
MOTHER 14. Maiden name Margaret Stonebult
15. Birthplace Germany

16 (a) Informant Mrs John Dawn
(b) Address 506 De Soto Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore

18 (a) Funeral director George A Tagley
(b) Address Fulton Ave & Gay St

19 (a) 1944 (Date received by registrar) (b) Harrington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1944, at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1936, to Feb 1 1944, and that I last saw h[illegible] alive on Feb 1 1944

Immediate cause of death	Duration
Cerebral Embolism	17/36/43
Due to Auricular Fibrillation	7/17/36
Due to Arteriosclerosis	?
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carey Rostney
Address 336 W Lombard St Date signed 2/7/44 M. D.

G 13808 G 13808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 13

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3743 Beech Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3743 Beech Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Thomas W. Athey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1873

8. AGE: Years	Months	Days	If less than one day
70	9	20	hr. min.

9. Birthplace Leesburg, Va. (Town, county, and state)

10. Usual Occupation Clerk - retired

11. Industry or business

FATHER
12. Name William W. Athey
13. Birthplace Va.

MOTHER
14. Maiden Name Isabella Rinker
15. Birthplace Va.

16 (a) Informant Emma E. Athey
(b) Address 3743 Beech Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month) (day) (year)
(c) Cemetery or crematory Union
Location Leesburg, Va.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5/1944 to 2/6/1944 and that I last saw him alive on 2/6/44 19

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis Heart Disease	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Zach R. Morgan
Address 6 E. Read St. Date signed 2/9/44 M. D.

E. Zachariah Morgan

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 13809 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 allendale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give locality)
(d) Street No. 215 allendale St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3 (a) FULL NAME Katharine D. Hunter

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Married

6 (b) Name of husband or wife Frederick R. Hunter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18, 1909

8. AGE: Years	Months	Days	If less than one day
34	3	18	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation home duties
11. Industry or business

MOTHER / FATHER
12. Name Marian L. Dunbar
13. Birthplace W. Va.
14. Maiden Name Minnie L. Crickenberger
15. Birthplace W. Va.

16 (a) Informant Mrs. Gladys D. Talbott
(b) Address 2723 St. Paul St —
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5, 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Taylor ave - Hamilton
18 (a) Funeral director John Mitchell Sons
(b) Address 600 Eutaw Place
19 (a) FEB 7 - 1944 (Date rec'd by registrar) (Signature) for Hollins H.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1944 at 6 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1938 to Feb 6 1944 and that I last saw h-er alive on Feb 6 1944

Immediate cause of death Nephritis — Duration 9 mos
Due to Acute Uremia
Due to Pulmonary Tuberculosis — 5 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J Edgar Talbott M. D.
Address 2723 St Paul St Date signed 2/6/44

VS 180

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G 13810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G 13810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2841 N. Calvert St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2841 N. Calvert (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sally Falls Darrell Atkinson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widowed

6 (b) Name of husband or wife James Inloes Atkinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1864

8. AGE: Years	Months	Days	If less than one day
79	6	30	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business

MOTHER / FATHER
12. Name Charles Darrell
13. Birthplace Bermuda
14. Maiden Name Letitia Falls
15. Birthplace Balto Md

16 (a) Informant Mrs Anne Louis Darrell
(b) Address Haywood & Paxton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8 44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md.

18 (a) Funeral director Henry W Jenkins Son Co
(b) Address 20 McCulloh Durham 5-15

19 (a) FEB 7 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944, at 8:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1944, to Feb. 6 1944, and that I last saw h[illegible] alive on Feb. 6 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 5 Days
Due to: Senile arteriosclerosis — Duration Indefinite
Due to:
Other Conditions: Pulmonary Congestion — Duration 1 Day.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry A Kelly M.D.
Address 2304 N. Paul St. Date signed 2/6/44.

VS 150

G 13811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13811

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Broadway - Fairmount Ave

(c) Hospital or institution: Church Home and Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore - 10 (If outside city or town limits, write RURAL and give town)

(d) Street No. 205 Stoney Run Lane (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Chilton Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1854

8. AGE: Years	Months	Days	If less than one day
89	6	15	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER

12. Name John Powell

13. Birthplace England

MOTHER

14. Maiden Name Sara Latham

15. Birthplace Maine

16 (a) Informant Bap Record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9 44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins & Son

(b) Address McCulloh & Orchard Sts

19 (a) (b) (Both to be filled by registrar) Registrar

7 — 1944

VS 15a

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944 at 12:22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1944 to 2-6 1944, and that I last saw h[illegible] alive on 2-5 1944.

Immediate cause of death	Duration
cardiac failure	3 months
pulmonary edema	3 months
Due to Arterio sclerotic Heart Disease	7 yrs
Due to	
Other Conditions Prostatic Hypertrophy Syphilis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Isabella Hanson M. D.

Address Church Home + Hosp. Date signed 2-6-44

13812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G 13812 Registered No. 1115 '81

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Sulphur Spring Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Laura

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28 1891

8. AGE: Years 52 | Months 9 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Phillip Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Laura
15. Birthplace Md

16 (a) Informant Mrs Fanny Garner
(b) Address 1711 Sulphur Spring Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10-44 (month) (day) (year)

(c) Cemetery or crematory Savage
Location Savage

18 (a) Funeral director Lloyd Kaiser
(b) Address Laurel Md

19 (a) FEB 7 1944 (Date received by Registrar) (b) Hunting for Williamson M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6/44 19 ... at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/[redacted]/44 to 2/6/44; and that I last saw him alive on 2/6/44.

Immediate cause of death: Cardiac Failure — Duration

Due to: Rheumatic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bryney M. D.
Address St. Agnes Hosp Date signed 2/9/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13813 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Harrison Blvd.
(c) Hospital or institution: Bout Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Belt St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Christine F. Spieker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John H. Spieker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7-1862

8. AGE: Years 81 Months 10 Days 29 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Henry Effing
13. Birthplace Germany

MOTHER
14. Maiden Name Adelaide Wescher
15. Birthplace Germany

16 (a) Informant Mrs. Eliason Oberender
(b) Address Belle Rd. Middleborough Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Elizabeth Earle Inc
(b) Address 115 E. West St.

19 (a) [illegible] (b) Huntington Williams MD Registrar

2-1944

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1944 at 7.5 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jan 5 1944 and that I last saw h[illegible] alive on Jan 5 1944.

Immediate cause of death (a) Bronchial Pneumonia — Duration 5 days

Due to

Due to

Other Conditions Chronic Arthritis Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address 727 Medical Arts Date signed 1-7-44

Physician's age is especially important. Physicians: please write the causes of death clearly and legibly.

13814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13814

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Jenkins Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Jenkins Memorial Hosp. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillie Mac Clements

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George MacClements
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10/58

8. AGE: Years	Months	Days	If less than one day
85	11	25	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Husing
13. Birthplace Germany

MOTHER
14. Maiden Name Mary--
15. Birthplace Unknown

16 (a) Informant Mr. Edw. MacClements
(b) Address 270 Colville Rd. Charlotte N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto. Md.

18 (a) Funeral director Philip Sauerwald
(b) Address 2024 Orleans St.

19 (a) FEB 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944 at 9 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1943 to Feb. 6 1944, and that I last saw her alive on Feb. 5 1944.

Immediate cause of death	Duration
Arteriosclerotic C-V-D	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur Rossini, M.D.
Address St. Agnes Hosp. Date signed 2/8/44

correct age is especially important. Physicians must write name and address of death certificate and return.

G 13815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 a

G 13815 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Fifth St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME George M. Acres

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced
M	W	

6 (b) Name of husband or wife Ida Florence Acres
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23rd 1871

8. AGE: Years	Months	Days	If less than one day
72	4	13	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired Construction Foreman
11. Industry or business C & P Telephone Co

FATHER
12. Name George M. Acres
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Timmons
15. Birthplace Virginia

16 (a) Informant Wanford Acres
(b) Address 4009 Fifth St. Brooklyn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St. Paul St.

19 (a) Date rec'd by registrar FEB 8 1944 (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1944, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1944, to 2/6 1944, and that I last saw h[illegible] alive on 2/6 1944

Immediate cause of death Pneumonia
Carcinoma of Kidney

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy Ca. of kidney & secondary growths in liver

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Md. Gen. Hosp. Date signed 2/6/44

correct age is especially important. Physicians, please write plainly. Use ink and typewriter ribbon.

13816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45D

Registered No. C 13816

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 E. 25th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Floyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ T. T. Floyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9th 1884

8. AGE: Years	Months	Days	If less than one day
59	2	28	hr. min.

9. Birthplace Kentucky
(Town, county and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Rev T. E. McCutchen
13. Birthplace Georgia

MOTHER
14. Maiden Name Lula Belle Richardson
15. Birthplace Kentucky

16 (a) Informant Mrs A. S. Blair
(b) Address Tampa Fla.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Marys
Location Hillsborough

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 FEB 8 1944 (Date received by Registrar) Hillsborough Co. Florida

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7th 1944, at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1943 to Feb 6 1944
and that I last saw h. alive on Feb 6 1944

Immediate cause of death: Carcinoma of Jaw with metastases. — Duration: Indef.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck.
Address 2727 N. Charles St. Date signed Feb 7-44

13817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G 13817 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2/2/44
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Chauncey Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MILTON KRAKOWER

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.- 224-05-3163

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Kate Zetlin
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) May 27, 1897

8. AGE: Years	Months	Days	If less than one day
46	8	6 9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Salesman-Oak Hall 5/30/43
11. Industry or business -

FATHER
12. Name Morris Krakower
13. Birthplace ? POLAN

MOTHER
14. Maiden Name Sarah Crook
15. Birthplace POLAND

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-44 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cemetary
Location Washington Blvd.
18 (a) Funeral director Goodman Levin Inc
(b) Address 1439 E Balto. St

FEB 8 - 1944 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Feb. 6, 1944, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1944, to Feb. 6, 1944, and that I last saw him alive on Feb. 6, 1944.

Immediate cause of death	Duration
Acute myocardia infaretion	Unk.
Due to	
Due to	
Other Conditions Hypertensive cardio-vascular disease (Include pregnancy within 3 months of death)	Sev. years

Date of operation None
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Gruss M. D.
Address Baltimore, Md. Date signed 2/7/44

Va-14280

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 13818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Parkland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5117 Gwynnbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Forb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Isaac Forb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1890

8. AGE: Years 53 54 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Austria

MOTHER
14. Maiden Name —
15. Birthplace Austria

16 (a) Informant Bessie F. Miller
(b) Address 5117 Gwynnbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location Wilkman Circle

18 (a) Funeral director Jack Levin Dec
(b) Address 1329 E. Baltimore St

19 (a) FEB 8 - 1944 (Date rec'd by registrar) (b) Permit for burial No. 8

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1944, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944 to Feb 7 1944, and that I last saw h e r alive on Feb 7 1944.

	Duration
Immediate cause of death Embolism	
Cardiac failure	
Due to Rheumatic fever	
cardio vascular heart disease	
Due to	
Other Conditions Diabetis mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reed W. Beckwith M. D.
Address West Baltimore General H. Date signed 2/7/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 13819 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 143 S. Linwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 S. Linwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE SCHLUDERBERG

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Schluderberg
6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Nov. 17, 1881

8. AGE: Years: 62 | Months: 2 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Butcher

11. Industry or business

FATHER
12. Name: Conrad Schluderberg
13. Birthplace: Germany

MOTHER
14. Maiden Name: Katherine Engle
15. Birthplace: Germany

16 (a) Informant: Mrs. Ella Schluderberg
(b) Address: 143 S. Linwood Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Colgate, Md.

18 (a) Funeral director: Ullrich Funeral Home.
(b) Address: 2008 Orleans St.,

FEB 8 - 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1943 to Feb 6 1944 and that I last saw him alive on Feb 6 1944

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to Myocarditis	6 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place or in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Louis Abramowitz M.D.
Address 1705 E. Balto St. Date signed Feb 7, 1944
Abramowitz

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13820
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Colgate
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Fairview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Nellie Ludwig 31853

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James M. Ludwig
6 (c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.) Aug 7 1912

8. AGE: Years 31 | Months 5 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Christolen
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Koutz
15. Birthplace Balto

16 (a) Informant James M. Ludwig
(b) Address 521 Fairview ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Wm. H. Funeral Home
(b) Address 804 E. Fayette St
Huntington Williams, M.D.

FEB 8 — 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1944 to Feb. 6 1944 and that I last saw her alive on Feb. 6 1944.

Immediate cause of death: pulmonary embolism — Duration: [illegible]
Due to: Pregnancy — Duration: [illegible]
Due to: — Duration: [illegible]
Other Conditions — Duration: [illegible]

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Christian F. Richter M. D.
Address St. Joseph's Hosp. Date signed 2/6/44

VS 250

G 13821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 13821
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 S New Kirk St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S Newkirk
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J Formallen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Elizabeth Formallen

6 (b) Name of husband or wife

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec 22 1873

8. AGE: Years 70 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Balto City

11. Industry or business Highway Dept

FATHER
12. Name Henry Formallen
13. Birthplace Balto

MOTHER
14. Maiden Name Dora Lenox
15. Birthplace Balto

16 (a) Informant Elizabeth Formallen
(b) Address 320 S New Kirk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Oliver St

FEB 8 - 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4/44 19 4:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1943 to Feb 4 1944, and that I last saw h alive on Feb 3 1944.

Immediate cause of death
Pulmonary tuberculosis
Arteriosclerotic C V Disease
Due to Chr myocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration
Nov 15 '43

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E A Schumacher M. D.
Address 842 S Eaton Ave Date signed 2-5-44

VS 180

correct age in typewriting. Physician: please write the causes of death clearly and legibly.

13822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13822
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mulberry & Caton Aves
(c) Hospital or institution St Agnes
(d) Length of stay in hospital or inst. ~~(yrs., mos.,~~ or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Haigis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 Months Mo Days If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unk
13. Birthplace Unk

MOTHER
14. Maiden Name Unk
15. Birthplace Germany

16 (a) Informant Sister St Agnes Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Rita Weedfield
(b) Address 914 Greenmount Ave

19 (a) FEB 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 / 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 2/6/1944.
and that I last saw her alive on 2/2/1944.

Immediate cause of death Diabetes Coma

Due to Diabetes Mellitus

Due to

Other Conditions Diabetic Gangrene left foot Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. T. Moore M. D.
Address St. Agnes' Hosp. - Date signed 2/6/44

correct age is especially important. Physician: please write the causes of death clearly and legibly.

13823 Feb 6/1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G 13823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2623 Freemont Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 4
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2623 Freemont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3. (a) FULL NAME Charles E Blaney.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 43 | Months — | Days — | If less than one day hr. min.

9. Birthplace New York City N.Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Chas Blaney.
13. Birthplace New York —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs H. Hastings
(b) Address 2623 Freemont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 8 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location —

18 (a) Funeral director Maynard Hudspeth
(b) Address 501 E 22nd St.

19 Filed FEB 8 1944 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5, 1944, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3, 1944 to Feb 5, 1944, and that I last saw him alive on Feb. 5, 1944.

Immediate cause of death: Myocardial insufficiency — Duration 2

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Guyton M.D.
Address 3963 Greenmount Ave Date signed 2/7/44

correct age in especially important. Physicians please write the cause of death carefully and legibly.

VS 150

G 13824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13824

170 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 S. Fremont Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 S. Fremont Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Joseph Mc Nicholas

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40	—	-	hr. min.

9. Birthplace Texas Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Welder

FATHER
12. Name William McN Nicholas
13. Birthplace Texas Md

MOTHER
14. Maiden Name Mollie Pace
15. Birthplace Texas Md

16 (a) Informant Mrs R. McN Nicholas
(b) Address 2 S. Fremont Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Memorial
Location

18 (a) Funeral director Mary M Waldefeld
(b) Address 201 E. 22nd Ste

19 (a) FEB 8 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7- 1944 at 8:40 A M

21. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Multiple fractures, lacerations, abrasions, contusions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-7-44 at 12.331 M.
(b) Where did injury occur? Frederick Rd at North Bend Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision with stone car

23. Signature Howard J. Cleveland M.D.
Medical Examiner.
Date signed 2-7-44

G 13825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 E. 20½ St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 E 20½ St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Dabney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1897

8. AGE: Years: d 47 | Months: 10 | Days: 25 | If less than one day: hr. min.

9. Birthplace Gloucester Co Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Richard Dabney
13. Birthplace Va

MOTHER 14. Maiden Name Laura Banks
15. Birthplace Va

16 (a) Informant Annie Isabell
(b) Address 308 E. 20½ St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 8 44 (month) (day) (year)
(c) Cemetery or crematory Shipped
Location Gloucester Co Va

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) FEB 8 - 1944 (Date rec'd by registrar) (b) Hunter Jon Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1944 at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to Feb 5 1944 and that I last saw h alive on Feb 5 1944.

Immediate cause of death: Cardiac Renal Disease — Duration: 5 mos
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. Johnson M. D.
Address 2529 Eutaw Date signed Feb 7 1944

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS 180

13826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 13826 Registered No.

Correct age is especially important—if unknown, please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 S Highland Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S. Highland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward C. Layton

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-8441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ada

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name James Layton
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Chiral
15. Birthplace ?

16 (a) Informant Ada Layton
(b) Address 320 S. Highland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location 7225 Eastern Ave

18 (a) Funeral director John J. Onda
(b) Address 2829 Hudson St.

FEB 8 - 1944 (Date rec'd by registrar) (by) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944. at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1939. to Feb 6 1944. and that I last saw h alive on Feb 6 1944.

Immediate cause of death	Duration
Myocardosis	
Due to Hypertension Heart Disease	
Due to Hypertension	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J. Gould M. D.
Address 1477 E Fort Ave Date signed 2-7-44

13827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G 13827 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Dillon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County do
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Dillon St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Emma R. Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widow

6 (b) Name of husband or wife John
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1873

8. AGE: Years	Months	Days	If less than one day
71	-	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Fred. Bellman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Harrington
15. Birthplace Baltimore

16 (a) Informant Louise Martin
(b) Address 2814 Dillon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Germany Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hilldale St.

FEB 8 - 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 19 44 at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to —

Other Conditions Pneumonia 1 week

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski M.D. Medical Examiner.
Date signed 2/8/44

VS 151

13828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13828
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506. Harlem ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506. Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora Commodore Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Felix Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8. 1906

8. AGE: Years 37 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace (Baltimore, Md)
(town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Joseph. Commodore
13. Birthplace Md

MOTHER 14. Maiden Name Bertha Smith
15. Birthplace Md

16 (a) Informant Bertha Commodore
(b) Address 1506. Harlem ave

17 (a) Burial (b) Date thereof 2-8-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington Memorial Park
Location Baltimore Md

18 (a) Funeral director Sam'l H. Chase & Son
(b) Address 638. N. Calvert St

19 FEB 8 - 1944 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1944 4:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/3/44 19 to 2/4 1944 and that I last saw h alive on 12/3/44.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Earl Cooke M. D.
Address 1131 Harlem Date signed 2/7/44

G 13829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 13829

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 3
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 Druid Park Drive
(If institutional, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie M. Baublitz

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem.	White	Married

6 (b) Name of husband or wife Clinton Baublitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6-1873

8. AGE: Years	Months	Days	If less than one day
70	9	—	hr. min.

9. Birthplace York Co. Pennsylvania
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Finney
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Catharine —
15. Birthplace Pennsylvania

16 (a) Informant Clinton Baublitz
(b) Address 2013 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10-1944 (month) (day) (year)
(c) Cemetery or crematory St. John's Lutheran
Location Parkville - Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

FEB 8 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944 at 10:28 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1944 to Feb. 6 1944.
and that I last saw her alive on Feb. 6 1944.

Immediate cause of death (a) Lobar Pneumonia — Duration

Due to

Due to

Other Conditions Pleural effusion.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz M.D.
Address St. Joseph's Hosp. Date signed 2-8-44

G 13830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92c

G 13830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4422 Rickford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1960 21st Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline R. Ranft

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25-1871

8. AGE: Years 72 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Charles D. Ranft
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia E. Schaible
15. Birthplace Maryland

16 (a) Informant Mrs. Aquilla B. Romeyn Jr.
(b) Address 4422 Rickford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 FEB 8 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6- 1944, at 7:30 P.M

21. I certify that death occurred on the date above stated; that attended deceased from Sept 1, 1943 to Feb 6/1944, and that I last saw h[illegible] alive on Feb 6/1944

Immediate cause of death
Coronary Occlusion
Due to Chron Rheumatic Endocarditis
Due to Arteriosclerosis

Duration 3 hrs.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Haveck M.D.
Address 1677 W Mount Ave Date signed 2/8/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 180

G 13831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190 G 13831 (Registered No.)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 S. Conkling St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace St. Joseph's Hospital Balt. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Franklin L. Smith
13. Birthplace York Co. Pa.

MOTHER
14. Maiden Name Florence Bodine
15. Birthplace Balto. Md.

16 (a) Informant Franklin L. Smith
(b) Address 205 S. Conkling St Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Prudence Cem. Co.
Location Severn Valley, R. R. 2

18 (a) Funeral director C. O'Loadeng
(b) Address Severn Valley, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1944 19 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944 to Feb 7 1944 and that I last saw her alive on Feb 7 1944

Immediate cause of death Diarrhea of new born — Duration

Due to —

Due to —

Other Conditions Possible erythroblastosis fetalis (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph's Hosp. Date signed 2-8-44

VS 250

13832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G 13832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 S. DECKER AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 S. DECKER AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN J. KESSLER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: MARGARET KESSLER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 19 1860

8. AGE: Years 83 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant JOSEPH KWSSLER (SON)
(b) Address 701 S. DECKER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 9/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilyand Zeiler INC.
(b) Address 403 S. WOLFE ST.

19. Date rec'd by registrar FEB 8 - 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 6 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1944 to Feb. 6, 1944, and that I last saw him alive on Feb. 6, 1944.

Immediate cause of death — Duration

Arterio-sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar Zeller, M.D. M. D.

Address 2739 Eastern Ave. Date signed 2/7/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3833 ✓ ✓ G 13833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Fairmount Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine A. Foeller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4, 1886

8. AGE: Years	Months	Days	If less than one day
57	6	3	hr. min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Morris
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Lavin
15. Birthplace Ireland

16 (a) Informant Joseph P. Foeller
(b) Address 2502 Fairmount Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Frederick Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 901 - 03 Hollins Street

19 FEB 8 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 - 1944 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to Feb 6 1944 and that I last saw h[illegible] alive on Feb 6 1944.

Immediate cause of death	Duration
Myocardial Failure	
Due to Generalized arteriosclerosis C.V. Disease	
Due to Carcinoma of Rectum	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan M. D.
Address 24 W. Fayette St Date signed 2/7/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

G 13834 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Greenslate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Roberta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug, 1880

8. AGE: Years 63 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation

11. Industry or business Watchman

FATHER
12. Name James Greenslate
13. Birthplace Kentucky

MOTHER
14. Maiden Name Mary ?
15. Birthplace Kentucky

16 (a) Informant Roberta Greenslate
(b) Address 1006 E Baltimore St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Feb, 8, 1944 (month) (day) (year)
(c) Cemetery or crematory South Portsmouth
Location Kentucky

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

FEB 8 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1944, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Febry 5 1944 to Feb. 7 1944
and that I last saw h[illegible] alive on Febry 7 1944

Immediate cause of death Chronic Nephritis — Duration 2

Due to

Due to

Other Conditions Uremic Coma

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverstein M. D.
Address 22 S. Broadway Date signed Feb 7 1944

Please write plainly. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

13835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 13835

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 McCulloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN S. SOLOMON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex m

5. Color or race Col

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1889

8. AGE: Years 54 | Months 4 | Days | If less than one day hr. min.

9. Birthplace La (Town, County, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Arnold Solomon
13. Birthplace La

MOTHER
14. Maiden Name Annie Simmons
15. Birthplace La

16 (a) Informant Martha Solomon
(b) Address 1434 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. B. Kelly
(b) Address 1323 Pleasant St

19 (a) [illegible] (b) Huntington, Indiana

FEB 8 - 1944
(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1944, at M

21. I certify that I took charge of the remains described above, held an ~~inquest~~ Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. L. Williamson M.D.
Attending Medical Examiner.
Date signed 2-6-44

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44826
13836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G 13836
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 E. 23rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clifton Chambers
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Lavenia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-91

8. AGE: Years 52 | Months 1 | Days 13 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business

FATHER
12. Name Armistead Chambers
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Hall
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Auburn Park
Location New Jersey

18 (a) Funeral director Geo. H. Kelbaugh
(b) Address 1302 Preston St

19 (a) FEB 8 1944 (Date received by registrar) (b) Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1944 at 7 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944 to Feb 7 1944 and that I last saw h alive on Feb 7 1944

Immediate cause of death	Duration
Bronchopneumonia	
Due to Adenocarcinoma of ? Stomach with metastases to Liver,	
Due to Arteriosclerosis & hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chaheen Levian M. D.
Address J. Hopkins Date signed 2-7-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 13837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Rosehill Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Rosehill Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oden R. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ella M.

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) June 14 1877

8. AGE: Years 69 | Months 7 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER
12. Name George Dorsey
13. Birthplace Md

MOTHER
14. Maiden Name Jemima Layfield
15. Birthplace Md

16 (a) Informant Ella Dorsey
(b) Address 521 Rosehill Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)

(c) Cemetery or crematory
Location Parklawn Cem

18 (a) Funeral director John C. Moran
(b) Address 3800 Balto St

19 Filed Feb 9 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1944, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1944, to Feb. 6, 1944, and that I last saw him alive on Feb. 6, 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days
Due to Arteriosclerosis	Unknown
Chronic Myocarditis	Unknown
Due to Chronic Nephritis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philibert Artigiani

Address 2942 E. Fayette St. Date signed 2/9/44

Philibert ARTIGIANI

(OVER)

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

G 13838
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town 5105 Whitford Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Md
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Fuhrman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9 1874

8. AGE: Years	Months	Days	If less than one day
70	10	26	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Jos Fuhrman
13. Birthplace Pa

MOTHER 14. Maiden Name Mary Jane Frame
15. Birthplace Pa

16 (a) Informant Gem L. Fuhrman
(b) Address 5105 Whitford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Fredajah Road

18 (a) Funeral director John E. Moran
(b) Address 3000 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 9 1944

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1943 to 2/5 1944 and that I last saw him alive on 1/5 1944.

Immediate cause of death Urinary peritonitis

Due to Urinary extravasation from bladder

Due to Ca of bladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca of bladder

of autopsy: Urinary peritonitis; Ca of bladder

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Lebedin
Address Sinai Hosp. Date signed M. D. 2/6/44

G 13839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 13839

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3412 E Fairmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 E Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Mc-Donough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~ widowed, or ~~divorced~~
Female	White	Widow

6 (b) Name of husband or wife Thos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 1877

8. AGE: Years	Months	Days	If less than one day
66	8	14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Thomas
13. Birthplace Wales

MOTHER
14. Maiden Name Elizabeth Rodriole
15. Birthplace Germany

16 (a) Informant Charles Rodriole
(b) Address 3412 E Fairmount Ave

17 (a) Burial (b) Date thereof 2/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Edmondson Road

18 (a) Funeral director John A Keenan
(b) Address 3800 E Baltimore St

FEB 8 - 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1944 at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1943 to Feb 6 1944, and that I last saw h alive on Feb 6 1944.

Immediate cause of death Hypertension
Arteriosclerosis CV Disease
Cerebral Hemorrhage

Duration
Dec 1943

Due to Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C A Schumacher M. D.
Address 642 S Ext Ave Date signed 2-7-44

VS 8

13840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13840 Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 Pitcher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Pitcher St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Ella Turner

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Richard Turner
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) March 14, 1875

8. AGE: Years 68 | Months 11 | Days 20 | If less than one day ——— hr. ——— min.

9. Birthplace Calvert Co. Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business Own home

FATHER
12. Name Wm. Freeland
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Calvert Co. Md

16 (a) Informant Mrs. Hilda Cathcard
(b) Address 660 St. Nicholas Ave. Ny.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 222 N. Schroeder St
FEB 8 - 1944 Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3-1944 at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21-1944 to 2-3-1944, and that I last saw her alive on 2-2-1944.

Immediate cause of death: Cerebral hemorrhage — Duration one day

Due to: Arteria Sclerosis — Duration unknown

Due to:

Other Conditions: Myocarditis — Duration unknown

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St. Date signed 2-7-44

VS 160

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 13841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 1150

Registered No. C 13841

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University 4th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) none

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Odenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Rumple

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1941

8. AGE: Years	Months	Days	If less than one day hr.	min.
2	11	29		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name ~~Duncan~~ Ralf J. Rumple

13. Birthplace Statesville, N.C.

MOTHER 14. Maiden Name Ethel M. Bryant

15. Birthplace Baltimore, Md.

16 (a) Informant Mother

(b) Address Odenton, Md.

17 (a) Burial at (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)

(c) Cemetery or crematory Troutman Cemetery

Location Statesville N.C.,

18 (a) Funeral director Ben L Hopping

(b) Address 170 West Annapolis, Md.

FEB 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1944. at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 1944. to 2/7 1944. and that I last saw h[illegible] alive on 2/7 1944.

Immediate cause of death Septicemia — Duration

Due to Pharyngitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Martin E. Strobel M. D.

Address Univ. Hospital Date signed 2/7/44

VS 150

Correct age in especially important. Physicians: please write the cause of death clearly and legibly.

13842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 13842

Correct age in appropriate space. If unknown, give approximate age. Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Edgewood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY W. CARROLL

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1876

8. AGE: Years	Months	Days	If less than one day
67	2	22	hr. min.

9. Birthplace Chestertown, Md. (Town, county, and state)
10. Usual Occupation Retired Teacher
11. Industry or business

FATHER
12. Name Wm. B. Carroll
13. Birthplace Chestertown

MOTHER
14. Maiden Name Henrietta Wright
15. Birthplace Md.

16 (a) Informant Miss Louise E. Carroll
(b) Address 2015 Longwood St. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Chester Cem.
Location Chestertown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by Registrar FEB 8 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1944, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1940 to Feb 7 1944, and that I last saw h~~er~~ alive on Feb 2 1944.

Immediate cause of death Myocarditis — Duration 2 weeks

Due to advanced arterio sclerosis & Hypertension — Duration ?

Due to Chronic Interstitial Nephritis — Duration Oct 1943

Other Conditions & Paralysis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter L. Abbott M. D.
Address 2220 Harrison Blvd Date signed Feb 8/44

G 13843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 13843 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1654 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton H Crout (Hezekiah Clinton Crout)

3 (b) If veteran, name war --

3 (c) Social Security Account No. 212-03-7636 A

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Jena H. Crout (Reese)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1874

8. AGE: Years 69 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and State)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John E. Crout
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah F. Brown
15. Birthplace Md.

16 (a) Informant Mr. Harry Crout
(b) Address 1654 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Asbury
Location Reisterstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 8 1944 (b)
(Date received by Registrar)

Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6 1944, at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1944 to 2-6 1944 and that I last saw h.[illegible] alive on 2-6 1944

Immediate cause of death Hemorrhage Coronary

Due to Trauma

Due to

Other Conditions Cirrhosis of liver T.B. of lung; Arterio. Heart Dis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myron S Avnick

Address Sinai Hosp. Date signed 2-7-44

G 13844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13844 Registered No. 830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. 245 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Anne Arundel, County (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Marion Hill
(b) Address Pasadena, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 10 44 (month) (day) (year)
(c) Cemetery or crematory Magothy Cem
Location A. A. County Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania Ave

19 (a) 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1944, at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Featherer M.D. Medical Examiner.
Date signed February 8, 1944

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G 13845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13845 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Harford
(a) State Maryland (b) County Forrest Hill
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Lee Jackson Carcaud

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wilton F. Jenkins
13. Birthplace Miss

MOTHER
14. Maiden Name — Harris
15. Birthplace Va

16 (a) Informant Harry A Carcaud
(b) Address Bel Air Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof July 10 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Deaver & Foster
(b) Address Bel Air Md

19 (a) 1944 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8/44 19 , at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1944 to 2/8 1944, and that I last saw h alive on 2/8/ 19 44

Immediate cause of death: Meningitis & terminal bron. Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Purulent exudate of the meninges

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan E. Chisolm

Address St. Joseph's Hospital Date signed 2/8/44

FEB 8 1944 [illegible] Registrar

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G 13846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13846 830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 N. Linwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 N. Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Pragg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 23 1859

8. AGE: Years	Months	Days	If less than one day
85		22 15	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Isah Pragg
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Miss Stella Busby
(b) Address 829 N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9, 44 (month) (day) (year)
(c) Cemetery or crematory Olivet Cem
Location Calvert Co. Md.

18 (a) Funeral director Cobb & Harkness
(b) Address Prince Frederick Md.

FEB 8 1944 (Date received by local registrar) Harrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1944 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1943 to Feb. 8 1944 and that I last saw him alive on Feb. 7, 1944.

Immediate cause of death Apoplexy — Duration 6 days

Due to Arteriosclerosis — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. B. Seybert M. D.
Address 2902 Harford Rd Date signed 2-8-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 13847 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2412 Crest Rd., Mt. Washington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Crest Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Cameron MacDonald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Kathryn MacDonald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1882

8. AGE: Years	Months	Days	If less than one day
62	0	29	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business Monumental Life Ins. Co.

FATHER
12. Name James F. MacDonald
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Graves
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Kathryn MacDonald
(b) Address 2412 Crest Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd. Balto. Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave

FEB 8 1944 (Date received by Registrar) (b)

Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION 7.30

20. DATE OF DEATH Feb. 8, 1944, at A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1943 to Feb. 6 1944, and that I last saw him alive on Feb. 3 1944.

Immediate cause of death
1) - Arterio - Sclerotic Heart disease
Due to c Hypertension.
Due to
Other Conditions - Coronary Thrombosis 1942 -
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations: None
of autopsy: No.

Duration
5 yrs?
-

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Earl L. Chambers
Address 4108 Liberty Hts. Ave Date signed 2/8/44 M D

Copy is especially important. Physicians: please write the causes of death clearly and legibly.

13848 HEALTH DEPARTMENT—CITY OF BALTIMORE G 13848

CERTIFICATE OF DEATH

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 516 Normandy Ave. 20 Ward)
Registered No. 1938
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Mamie Richardson
If U. S. Veteran specify WAR ...

(a) Residence: No. 516 Normandy Ave. Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. Color or Race: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Whitefod W. Richardson
6. DATE OF BIRTH (month, day, year): July 26, 1902
7. AGE: Years: 41; Months: 6; Days: 12; If LESS than 1 day, ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: House-wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Charlotte, N.C.

FATHER
13. NAME: Charles Thomas
14. BIRTHPLACE (city or town) (State or country): Baltimore Md

MOTHER
15. MAIDEN NAME: Nora
16. BIRTHPLACE (city or town) (State or country): Norfolk, Va

17. INFORMANT: Whitefod W. Richardson
(Address) 516 Normandy Ave
18. BURIAL, CREMATION, OR REMOVAL
Place: Charlotte, N.C. Date: 2-10-44
19. UNDERTAKER: J. Francis Reese
(Address) Westmount Md
20. FILED ... 19... Huntington Williams, Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): 2/8, 1944
22. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1943 to Feb. 8, 1944
I last saw him alive on Feb. 6, 1944. Death is said to have occurred on the date stated above, at 11 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	4yrs

Other contributory causes of importance:

Was an operation performed? No Date of ...
For what disease or injury? ...
Name of operation ...
What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? No Date of injury ..., 19...
Where did injury occur? ...
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place ...
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Bond Lehman, M. D.
(Address) 3921 Edmondson Ave

OCCUPATION is very important. See instructions on back of certificate.

B 8 - 1944

LEONA. KOCHMAN

HEALTH DEPARTMENT—CITY OF BALTIMORE

13849 13849

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Julius Begum

If U. S. Veteran specify WAR

(a) Residence: No. 440 N Biddle St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Mary Brown

6. DATE OF BIRTH (month, day, year) Oct 5, 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55 56	4	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Carpenter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Anne Arundel Co

FATHER

13. NAME Joseph Brown

14. BIRTHPLACE (city or town) (State or country) Calvert Co Md

MOTHER

15. MAIDEN NAME Harriet Whittington

16. BIRTHPLACE (city or town) (State or country) Calvert Co Md

17. INFORMANT Mary Brown

(Address) 440 N Biddle St

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Zion Date Dec 9, 19 44

19. UNDERTAKER Wm. Francis A. Hemsley

(Address) 578 W. Biddle St

20. FILED Dec 11, 19 44 Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec 6 1944

22. I HEREBY CERTIFY, That I attended deceased from Dec 4 1944 to Dec 6 1944

I last saw him alive on Dec 6 1944. Death is said to have occurred on the date stated above, at 8.31 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertrophy of Prostate	?
Acute Urinary Retention	3 days
Chr. Nephritis	
Influenza	

Other contributory causes of importance:

Was an operation performed? Yes Date Dec 5 1944

For what disease or injury? Acute Retention

Name of operation Supra-Pubic Cystotomy

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Bernard Harris M. D.

(Address) 1427 N Carlton St.

Bernard Harris, M.D.

G 13850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 13850

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1869

8. AGE: Years 74 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas Young

13. Birthplace Md

MOTHER 14. Maiden Name Caroline ?

15. Birthplace Md

16 (a) Informant Mr. Alvin Young

(b) Address 1821 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 548 W. Biddle St.

19 44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1944, at 3:5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1944 to Feb. 7 1944, and that I last saw h[illegible] alive on Feb. 7 1944.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L L Banfield M. D.

Address Provident Hospital Date signed 2-8-44

VS 180

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G 13851 G 13851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6113 Alta Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6113 Alta Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ulrich H. Nickel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Wh

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife Eva Eff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1858

8. AGE: Years 85 | Months 11 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Supt. of brick yard

11. Industry or business Brick

FATHER
12. Name Christian Nickel
13. Birthplace Germany

MOTHER
14. Maiden Name Fredericka
15. Birthplace Bermany

16 (a) Informant Mrs. May E. Cronhardt
(b) Address 6113 Alta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or CREMATORY London Park
Location Baltimore Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 19 44 at 11.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23rd 19 44 to Feb 6 19 44, and that I last saw him alive on Feb 5 19 44.

Immediate cause of death	Duration
Cardiac Irsufficiency	3 days
Due to Chronic Nephritis	Yrs.
Due to Arteriosclerosis	Many yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M.D. M. D.
Address 5713 Bal Air Rd. Date signed 2-7-44

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13852

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13852 Registered No. 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Guilford Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E. Wallis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1885

8. AGE: Years 58 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business

FATHER
12. Name Samuel W. Wallis
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Lynch
15. Birthplace Md.

16 (a) Informant Harry Bullock
(b) Address 1804 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9/44. (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Harry H. Mitchell
(b) Address 4401 Edmondson Ave. Huntington Pittsville, Md.

19 (a) 1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1944, at 7:55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1943, to Feb. 6, 1944 and that I last saw her alive on Feb. 4, 1944.

	Duration
Immediate cause of death: Chronic Myocarditis	12 months
Due to Chronic Endocarditis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Ogden, M. D.
Address 2701 N. Calvert. Date signed Feb. 8, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13853 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry A. Bendt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Kate Emma T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1914

8. AGE: Years	Months	Days	If less than one day
29	7	12	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Machinist Helper
11. Industry or business B. & O. R. R.

FATHER
12. Name Henry
13. Birthplace Balto.

MOTHER
14. Maiden Name Amelia
15. Birthplace Balto.

16 (a) Informant Mrs. Henry W. Bendt
(b) Address 24 N. Ashburton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmonson Ave. & Longwood

18 (a) Funeral director Harry H. Little
(b) Address 4101 Edmondson Ave

19 (a) 2-8-1944 (b) Registered by Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1944, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1944 to 2/6 1944 and that I last saw h[illegible] alive on 2/6 1944.

Immediate cause of death Nerve Sheath Tumor (cancer) Rt hand & metastasis to lungs — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Nerve Sheath Tumor Rt hand

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. T. Muse

Address St. Agnes' Hosp. - Date signed 2/6/44 M.D.

G 13854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

80B

G 13854

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Wastelli Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa A Falk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1896

8. AGE: Years 47 Months 3 Days 19 30 If less than one day hr min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Thomas Falk

13. Birthplace Balto., Md

14. Maiden Name Anna Rheinhardt

15. Birthplace Balto., Md

16 (a) Informant Mrs. Helen Hitzel

(b) Address 1 Wastelli Ave. Arbutus Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Witte

(b) Address 4016 Edmondson Ave

19 (a) 1944 (Date rec'd by registrar) (b) Arlington Williams M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1944 at 12 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 6 1944 and that I last saw her alive on Feb 6 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Unexplained fever Encephalitis??	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. R. Humphries

Address Mercy Hosp Date signed 2/6/44

VS 180

G 13855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G 13855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 138 South Potomac St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 S. Potomac St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura E. Mech.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George P. Mech

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) June 30, 1878

8. AGE: Years 65 Months 7 Days 6 If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Charles F. Lutz
13. Birthplace Germany.

MOTHER
14. Maiden Name Frederikka Bliech
15. Birthplace Germany

16 (a) Informant Mr. George P. Mech.
(b) Address 138 S. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9, 44 (month) (day) (year)
(c) Cemetery or crematory Schwartz Cemetery
Location Donnell St.

18 (a) Funeral director S. Walter May
(b) Address 649 N. Bouldin St.

19 (a) FEB 8 - 1944 (Date rec'd by registrar) writing for Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1944, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1943 to Feb 5 1944
and that I last saw h[illegible] alive on Feb 5 1944.

Immediate cause of death: Hypostatic Pneumonia — Duration 2 Days
Due to: Pneumonia of Lung — 11/43
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Swann M.D.
Address 801 Keyworth Date signed 2/3/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Maryland House 2 Corners (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GILBERT HOLMES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 8 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1944, at 7P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 1-2-44
(a) Date of injury 1-27-44 at M.
(b) Where did injury occur? Philadelphia Rd. Baltimore County
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature H. L. Williams M.D. Medical Examiner.
Date signed

0719

Please write plainly; physicians: please write the causes of death clearly and legibly.

G 13857

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13857
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 N. Castle Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 N. Castle Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? Life years

3 (a) FULL NAME Louise W. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William H. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1882

8. AGE: Years	Months	Days	If less than one day
61	10	6	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation House work at Home
11. Industry or business

FATHER
12. Name Bruce Osterstock
13. Birthplace Richmond, Virginia

MOTHER
14. Maiden Name Susanna Meyers
15. Birthplace Baltimore Maryland

16 (a) Informant Mr. Edward W. Hamilton
(b) Address 1823 N. Castle Street

17 (a) Burial (b) Date thereof 2-11-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E. North Ave. Extended

18 (a) Funeral director Albert L. Nitzberg
(b) Address 1606 N. Chester Street

19 (a) Date received by Registrar (b) Keating for Williams, M.D. Registrar

FEB 8 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1944 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1944 to Feb. 7 1944, and that I last saw her alive on Feb. 7 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 yr.
Due to	
Due to	
Other Conditions Diabetis Mellitus	4 yrs.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Frahm M. D.
Address 1823 N. Castle St. Date signed 2/8/44

G 13858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 837

G 13858 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4607 Frankford ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4607 Frankford ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Zimmer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna V. Zimmer
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug 18-1867

8. AGE: Years	Months	Days	If less than one day
75	5	18	hr. min.

9. Birthplace Reading Pa.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Robert Zimmer
13. Birthplace Pa.

MOTHER
14. Maiden Name Jenny Mans
15. Birthplace Germany

16 (a) Informant Mrs Anna V. Zimmer
(b) Address 4607 Frankford a

17 (a) Burial (b) Date thereof 2-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leonard Myers
(b) Address 5205 Harford Rd

19 (a) 1944 (b) Huntington Williamsport Md
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1943 to Feb 6 1944.
and that I last saw [illegible] alive on Feb 6 1944.

Immediate cause of death	Duration
Progressive Hemiplegia	9 Mo.
Due to Arterio-Sclerosis	2 y.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Valentine M. Daily
Address 176 N Broadway Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13859
AB-

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13859
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs-2mos-19days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 S. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Sobczynski (Sobyczewski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John Sobczynski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-1871

8. AGE: Years	Months	Days	If less than one day
73	?	?	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John ? Matuszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Poland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address RECORDS

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Balto. City

18 (a) Funeral director Mrs Mary Weber
(b) Address 491 S. Chester St

19 (a) 1944 (b) Wesley Williams Registrar
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1944 at 5:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/44 19 to 2/4 1944, and that I last saw h[illegible] alive on 2/4 1944.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to Hypertensive Cardiovascular disease

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: cerebral hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl P. Kinney M. D.
Address Balt. City Hospitals Date signed 2/4/44

G 13860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G 13860
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Northway Apartments
(b) Street address 3700 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Evelyn M. Weisz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles E. Weisz
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 68	---	---	-- hr. -- min.

9. Birthplace Brooklyn, New York (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Charles A. McMurray
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Anna Russell
15. Birthplace New York State

16 (a) Informant Miss Irene M. Weisz
(b) Address 3700 N. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn, New York

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) FEB 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150 Via Pennsylvania Railroad

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1938 to Feby 6 1944 and that I last saw h alive on Feby 6 44

Immediate cause of death	Duration
Carcinoma	
Metast - Metastases	
Due to Abdominal Glands	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1938
Major findings of operation: Carcinoma Metastases
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. J. Kirby M. D.
Address 110 E Northam Date signed 2/8/44

G 13861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 13861

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 N. Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara W. Tehill Fortl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jay Tehill Fortl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12 - 1874

8. AGE: Years 69 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name John Lindner

13. Birthplace Balto Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs Eliz. Hughes

(b) Address 2625 Ellwelyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location Eastern Ave. Balto Md

18 (a) Funeral director John C. Milly Fac

(b) Address 2435 E. Oliver St

(c) 2-8-44 (Date received by registrar) Huntington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 6 - 1944, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1943, to February 6 1944, and that I last saw her alive on February 5 1944.

Immediate cause of death: Complete Heart Block

Due to

Due to

Other Conditions: Diabetes Mellitus (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration: 2 months 27 Days; 1 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Eisenberg

Address 2025 E. North Ave Date signed 2/7/44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

5862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157c

G 13862
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution: University Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15da
(e) Length of stay in Baltimore (yrs., mos., or days) 15-da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 Bunsen Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Gloria Jean Bucher

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem'l	Negro.	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		15da	— hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William Bucher
13. Birthplace North Carolina

MOTHER
14. Maiden Name Beulah May Lloyd
15. Birthplace North Carolina

16 (a) Informant Janie Lloyd Grandmother
(b) Address 1137 Bunsen St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Body is to become
Location the property of the

18 (a) Funeral director dept of Pathology,
(b) Address University of Maryland

FEB 8 - 1944
(date rec'd by registrar) (b) Huntington Williams M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 19 44 at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 19 44 to Feb 4 19 44 and that I last saw her alive on Feb 4 19 44.

Immediate cause of death	Duration
Congenital weakness	
Due to	
Due to	
Other Conditions Anencephalus	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin J. Jaworski

Address University Hospital Date signed 2/9/44 M. D.

correct age is especially important. Physician: please write plainly with pen and ink. Do not use pencil. Sign in ink.

G 13863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13863 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 W. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 W. Montford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Cermak

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna L. Cermak
6 (c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) May 5, 1868

8. AGE: Years	Months	Days	If less than one day
75	9	1	hr. min.

9. Birthplace Czecho-Slovakia (Town, county, and state)
10. Usual Occupation Marine Carpenter
11. Industry or business

FATHER
12. Name John Cermak
13. Birthplace Czecho-Slovakia

MOTHER
14. Maiden Name Not known
15. Birthplace " "

16 (a) Informant Anna Cermak
(b) Address 926 W Montford Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.
18 (a) Funeral director Frank Brockbank
(b) Address 900 W. Chester St
19 (a) Date received by registrar FEB 8 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944 at 7:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1943 to Feb. 6 1944 and that I last saw h alive on 2/5 1944.

Immediate cause of death Hypertension Cardio-Vascular Renal Disease. — Duration 3 yrs.
Due to —
Due to —
Other Conditions Bronchopneumonia (Include pregnancy within 3 months of death) — Duration 6 Days
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert F. Sekunda M. D.
Address 2939 W Baltimore Date signed 2/6/44

Copper age is especially important. Physicians: please write the name of the county and city.

G 13864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1/21a

G 13864 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 S. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Pulaski Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** George Arthur DeHoff

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary V. DeHoff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1875

8. AGE: Years 68 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Catonsville Balto. County, Md. (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Self

FATHER
12. Name George P. DeHoff
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Deaver
15. Birthplace Maryland

16 (a) Informant Mary V. DeHoff
(b) Address 305 S. Pulaski Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto. County, Maryland.

18 (a) Funeral director George W. Schmidt
(b) Address 2101 Frederick Avenue

19 (a) 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. District No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1944 at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Feb 7 1944 and that I last saw h[illegible] alive on Feb 7 1944

Immediate cause of death: acute cardiac failure — Duration 3 days
Due to: uremia — Duration 3 days
Due to: Chr. Nephritis — Duration ?
Due to: Chr. Myocarditis — Duration ?
Other Conditions: Arteriosclerosis — Duration ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. M. Kistler M. D.
Address 2478 Druid Hill Ave Date signed 2-7-44

Correct age is especially important. Physicians, please answer every question.

JO Issue G 13865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13865 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Hilmar Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn Fraction

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1926

8. AGE: Years	Months	Days	If less than one day
17	6	23 13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alfred Fraction
13. Birthplace Md.

MOTHER
14. Maiden Name Pearl Stewart
15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Baltimore Ave

FEB 8 - 1944 (Date received by Registrar) (By) Hunter Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 19 1944, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 19 44. to 1-30 1944, and that I last saw h[illegible] alive on 1-30 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Hartman M. D.

Address B. C. H. Date signed 1/30/44

Please write plainly. Physicians: please write the causes of death clearly and legibly. Cause given is especially important.

G 13866 ✓ G 13866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos- 8days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Flemming Drive-Dundalk-Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Perrish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12-1899

8. AGE: Years	Months	Days	If less than one day
44	1	24	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Charity (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Grimes
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley Ave

FEB 8 - 1944 (b)
(Date received by registrar) Herrington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1944, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1943 to 2/5 1944.
and that I last saw h alive on 2/5 1944.

Immediate cause of death	Duration
(a) cerebral accident	?
Due to (b) H.C.V.D.	?
Due to (c)	
Other Conditions, Old left Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M. D.
Address 13 CH Date signed 2/6

Fill in age in capitals. Physicians: please write the causes of death clearly and legibly.

G 13867 ✓ G 13867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 S. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Babe Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rosa Austin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1877

8. AGE: Years 66 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Littleton, N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Wash Austin

13. Birthplace N. C.

MOTHER 14. Maiden Name Margaret Boyd

15. Birthplace N. C.

16 (a) Informant Rosa Austin

(b) Address 102 S. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery

Location

18 (a) Funeral director Elroy Wilson

(b) Address 1000 Bramtly Ave

FEB 8 - 1944 (Date rec'd by registrar) (b) Registrar

VS 180

Flemington for Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1944, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1944 to Feb 5 1944 and that I last saw h/ him alive on Feb. 5 1944

Immediate cause of death Arteriosclerosis Anemia

Due to Adrenal deficiency

Due to

Other Conditions Anes Hernia Urinary disturbance (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. H. Finnecce

Address 1422 E. Chase Date signed Feb 7-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13868 Registered No. 131B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	Widowed

6 (b) Name of husband or wife Mamie Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1881

8. AGE: Years	Months	Days	If less than one day
62	3	22	hr. min.

9. Birthplace Cambridge / Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Madeline Williams
(b) Address 614 N. Carey st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley Ave

FEB 8 – 1944 (Date received by Registrar) (b) Lee Williams, M.D. Registrar

VS 189 – 6

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1944 at 9:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2·1·1944 to 2·4·1944, and that I last saw h alive on 2·4 1944

Immediate cause of death: Acute myocarditis
Due to: Bronchial Asthma
Chr. nephritis
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: 2 days; 7 yrs.; 6 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Berry
Address 420 E. Chase Date signed 2-7-44

Correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G 13869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 13869 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 42 N Monastery
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 42 N Monastery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Herman Amer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Widower.

6 (b) Name of husband or wife Mary C. Caswell (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
87	-	-	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business Baker.

FATHER
12. Name Chas Amer
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Zighion
15. Birthplace Germany.

16 (a) Informant Mrs Hartman
(b) Address 42 Monastery

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Dept Suspended

18 (a) Funeral director J. J. Tobey & Sons
(b) Address 1918 Eight St

19 (a) FEB 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1944, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1944 to Feb 6 1944 and that I last saw h[illegible] alive on Feb 6 1944.

Immediate cause of death > Pneumonia Terminal — Duration 2 days
Due to Cardio Vascular Renal Disease Chronic Nephritis — 1 Year
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eliot Wyatt Williams M. D.
Address 2432 Fredrick - Date signed

448999

13870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13870

Registered No. 1342

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Upper Darby (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Elm Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Malison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-6-11

8. AGE: Years	Months	Days	If less than one day
32	9	2	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Artist
11. Industry or business

FATHER
12. Name Harry Malison
13. Birthplace Russia

MOTHER
14. Maiden Name Fanny ?
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon Location Phila Penna.

18 (a) Funeral director Sol Lennon Bros
(b) Address 1124 W North ave

FEB 9 1944 (Date received by registrar) (b) Huntington Wilkinson M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1944 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1944 to Feb 8 1944 and that I last saw he alive on Feb 8 1944

Immediate cause of death Uraemia
Cardiac failure — Duration

Due to Renal insufficiency

Due to Recurrent Renal calculi - staghorn

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 1941
Major findings of operation: renal calculi
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell R. Roth
Address Johns Hopkins Hosp Date signed 2/8/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. G 13871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Maternity Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot
(c) City or town Easton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Ann Grace (Julia Ann Grace)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 21 - 1920

8. AGE: Years 23 | Months 3 | Days 16 | If less than one day — hr. — min.

9. Birthplace Talbot Co. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name W. S. Grace 3rd.
13. Birthplace Talbot Co.

MOTHER
14. Maiden Name Betty Stonesifer
15. Birthplace Penna.

16 (a) Informant Mrs. Betty Grace (Mother)
(b) Address Easton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10-1944 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cemetery
Location Easton, Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 106 West North Ave. Balto, Md.

19. (a) FEB 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1944 at 3:54 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1944 to 2/7 1944 and that I last saw her alive on 2/7 1944.

Immediate cause of death: Cerebellar Tumor — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/5/44

Major findings of operation: Cerebellar Tumor

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen L. Jamanka M. D.
Address Maternity Hospital Date signed

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G 13872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

Registered No. G 13872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Nuruma Ave & Rutland Ave
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2-2 Mean

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 N. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Bergen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary Lee Copenheaver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 31 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Clerk (Relf)

11. Industry or business

FATHER
12. Name Isaac Bergen
13. Birthplace Russia

MOTHER
14. Maiden Name Mulley
15. Birthplace Russia

16 (a) Informant Mary Bergen (Wife)
(b) Address 100 N. ~~Wolfe St~~ Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto. St

FEB 9 1944 (Date received) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-44 1944, at 5.30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 7-10 1943 to 2-8 1944, and that I last saw him alive on 2-3 1944.

Immediate cause of death Cachexia — Duration

Due to Generalized tuberculosis, pulmonary & genitourinary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec. 1943

Major findings of operation: Tuberculous epididymis

Autopsy Pulmonary + G.U. tbc.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lyman J. Lyon M. D.

Address Sinai Hospital Date signed 2-8-44

VS 180

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G 13873 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Usual address 1829 No Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 No Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sam Flitman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day hr.	min.
65				

9. Birthplace Russia (Town, county and state)
10. Usual Occupation Plumber (retired)
11. Industry or business

FATHER
12. Name Shaiea
13. Birthplace Russia

MOTHER
14. Maiden Name Zimma
15. Birthplace Russia

16 (a) Informant Charles Flitman
(b) Address 1829 No Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location German Hill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1719 E Balto St

19 FEB 9 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1944, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1941, to 2-4 1944, and that I last saw h[illegible] alive on 2-4-1944

Immediate cause of death	Duration
arteriosclerotic heart disease	2 y.
Due to Hypertension	1941
Bronchial asthma	2
Due to	
Other Conditions Ulcer of Duodenum, with hemorrhage	1941

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. A. Michelsen M. D.
Address 2230 Eutaw Pl Date signed 2/9/44

VS 180

G 13874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. G 13874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Spaths Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1126 Spaths Lane (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anny Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
female	Colored	married

6 (b) Name of husband or wife Wesley Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17-1878

8. AGE: Years	Months	Days	If less than one day
63	3	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Braxton Stokes
13. Birthplace Maryland

MOTHER
14. Maiden Name Teague Lewis
15. Birthplace Maryland

16 (a) Informant Laura Stewart
(b) Address 2835 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port

18 (a) Funeral director Va Brooks
(b) Address 1437 N. Carey St.

19 (a) FEB 9 - 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1944, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to Feb 7 1944, and that I last saw h— alive on Feb 7 1944.

Immediate cause of death Cardio. Renal Disease — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irene D. Johnson M. D.
Address 2329 Presstman Date signed Feb. 8 1944

VS 3

13875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937 ✓ G 13875

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: A.A.Co.
(a) State Md (b) County
(c) City or town Baltimore – 25 Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 452 1 R.F.D. 9 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Effie G. Tildon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife Thomas L. Tildon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1879

8. AGE: Years	Months	Days	If less than one day
64	7	10	hr. min.

9. Birthplace Michaelsville Harford Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Isaac C. Williams
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Nancy Pitts
15. Birthplace Harford Co. Md.

16 (a) Informant Thomas L. Tildon
(b) Address Milford Ave Patapsco Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9-44 (month) (day) (year)
(c) Cemetery or crematory Aberdeen Md.
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 3229 N. Calvert St

FEB 9 1944 (Date received by registrar) (b) Cantin for Williams

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6 1944 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1944 to 2-6 1944, and that I last saw her alive on 2-6 1944.

Immediate cause of death Hypertensive cardiovascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R. Macdonald M. D.
Address 1213 Light St Date signed 2-6-44

13876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51c

Registered No. G 13876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 N. Collington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 N. Collington Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Matthew Thomas Dodson

3 (b) If veteran, name war No

3 (c) Social Security Account No. 405-03-9570

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ruby Bessy Wright 6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1889

8. AGE: Years	Months	Days	If less than one day
54	4	14	hr. min.

9. Birthplace Sardis, Miss. (Town, county, and state)
10. Usual Occupation ventilating engineer
11. Industry or business Glen L. Martin Co.

FATHER
12. Name Thomas Dodson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ellen White
15. Birthplace North Carolina

16 (a) Informant Ruby B. Dodson
(b) Address 130 N. Collington Ave.

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory Radcliffe
Location Pikeville, Kentucky

18 (a) Funeral director M. W. Ed. Dippel's Sons
(b) Address Lombard & Ann Sts.

19 (a) FEB 9 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1944, at 4:5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1943, to 2-9 1944, and that I last saw him alive on 2-9 1944.

Immediate cause of death: Acute cardiac failure — Duration: 7

Due to

Due to

Other Conditions Hodgkin disease — 7 mos.

(Include pregnancy within 3 months of death)

Date of operation 11-13-43, 1-21-44

Major findings of operation: Seminoma, left testicle. Hodgkin disease

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis M. Lupo

Address 11 E. Chase St. Date signed 2/9/44 M. D.

13877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

V G 13877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALICE ESTELLE McLAUGHLIN

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/29/1873

8. AGE: Years	Months	Days	If less than one day
70	4	8	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Patrick McLaughlin
13. Birthplace Ireland

MOTHER 14. Maiden Name Emily L. Miles
15. Birthplace Balto., Md.

16 (a) Informant Miss Marie McLaughlin
(b) Address 1010 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 9 - 1944 (b) [illegible] Registrar
(State registrar or registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1944 at 1.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944, to Feb 7 1944, and that I last saw her alive on Feb 7 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3737 W North Ave Date signed 2/7/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C-13878

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IDA A. DUSHANE

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Walter Dushane, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1858

8. AGE: Years	Months	Days	If less than one day
85	9	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry B. Lippy
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Harrison
15. Birthplace Md.

16 (a) Informant Mrs. Walter Dushane, Jr.
(b) Address 1709 N. Hilton St. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1944, at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1944, to Feb. 8, 1944, and that I last saw her alive on Feb. 6, 1944.

Immediate cause of death Congestive heart failure — Duration 6 days
Due to Chronic myocarditis — 2 yrs
Due to arterio-sclerosis — ?
Other Conditions Senility

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice L. Shamer
Address 3300 W. Northern Date signed 2/8/44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13879 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ulena Sorell

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Hosea

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/26/1879

8. AGE: Years 65 | Months - | Days 13 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Jefferson Johnson

13. Birthplace md

MOTHER 14. Maiden Name Nelke Kane

15. Birthplace md

16 (a) Informant Lizzie Joyner

(b) Address 1109 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Md

18 (a) Funeral director Wm. H. Kelson

(b) Address 1303 Pressman St

FEB 9 - 1944 (Date rec'd by registrar) (b) Interred for Millington Md (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1944 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1943 to Feb. 8 1944.
and that I last saw h[illegible] alive on Feb. 8 1944

Immediate cause of death Uremia — Duration 1 week

Due to Hypertension Cardiovascular Disease

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Ralph W. Redden Jr.

Address 426 N. Calhoun St Date signed 2/9/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

3880 1939-0

G 13880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

93 D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 Westwood Ave St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 4 Yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

15

2. FULL NAME William Simms

(a) Residence: No. 1637 Westwood Ave St., ... Ward. .....

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Simms

6. DATE OF BIRTH (month, day, year): 1889

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
55 54			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Jamaica, B.W.I.

FATHER

13. NAME: —

14. BIRTHPLACE (city or town) (State or country): —

MOTHER

15. MAIDEN NAME: —

16. BIRTHPLACE (city or town) (State or country): —

17. INFORMANT: Annie Simms

(Address) 1637 Westwood Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Calvary Date 2/10/44, 19...

19. UNDERTAKER: Geo. G. Gelson

(Address) 1307 Pennsylvania Ave

FEB 10 1944 Huntington Woodlawn

20. FILED ..... 19... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Feb. 7, 1944

22. I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1944, to Feb 7, 1944

I last saw him alive on Feb 4, 1944. Death is said to have occurred on the date stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Edema	3 wks
Other contributory causes of importance: Cardio-Vascular Disease	?

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19...

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) W. Donald Bando M. D.

(Address) 1475 Druid Hill Ave. Balto., Md.

V. S. 3 OCCUPATION is very important. See instructions on back of certificate.

G 13881

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 13881

93F

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2200 Mayfield ave. ST.: | WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. (J.) Edward Cook. (Jr) Sr

(a) RESIDENCE. NO. 2200 Mayfield Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Agatha Cook.

6 DATE OF BIRTH (month, day, and year) Dec. 24th 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59 years	1 mo.	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Practice of Medicine.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Edward Cook Sr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Rock

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Leo D. Cook (Address) 1705 N. Patterson Park Ave

15 FEB 9 - 1944 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1944

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1943, to Feb. 6th, 1944, that I last saw him alive on Feb. 6th, 1944, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

(Address) 1101 St. Paul St. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	2-10th 1944
20 UNDERTAKER	ADDRESS
Leo D. Cook	1705 N Patterson Park Ave.

13882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13882
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 Poplar Grove St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Theresa Higdon

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife John E. Higdon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 24, 1871

8. AGE: Years	Months	Days	If less than one day
72	10	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Eizer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Shiner
15. Birthplace Balto. Md.

16 (a) Informant Miss Magdalene Higdon
(b) Address 934 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Ritchie Highway

18 (a) Funeral director Fred. A. Klausner Son
(b) Address 126 S. Charles St.

19 (a) FEB 9 - 1944 (Date rec'd by registrar) (b) Registered FEB 11 1944 (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5, 1944 19 at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1944, to Feb. 5 1944, and that I last saw h alive on 19

Immediate cause of death	Duration
Hypertension	
Cardio Vascular Disease	
Diabetes Mellitus	
Due to Chronic Nephritis	
Due to	
Other Conditions Pulmonary Oedema.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mildred E. Wilson M. D.
Address 2151 Wilkens Ave. Date signed 2-7-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

13883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13883
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address --
(c) Hospital or institution: Station Hospital Holabird Signal Depot, Balto. 19, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminister (If outside city or town limits, write RURAL, and give town)
(d) Street No. R.F.D. #4 (If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country

3 (a) FULL NAME MELVIN ROY WARE

3 (b) If veteran, name war --
3 (c) Social Security Account No. 198-12-1251

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mamie L. Ware
6 (c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) 6-3-1889
8. AGE: Years 54 | Months 8 | Days 6 | If less than one day -- hr. -- min.
9. Birthplace Atlanta, Ga.
10. Usual Occupation Assistant Safety Engineer
11. Industry or business Civil Service Employee

FATHER
12. Name Melvin M. Ware
13. Birthplace Atlanta, Ga.

MOTHER
14. Maiden Name Mary J. Hardage
15. Birthplace Marietta, Ga.

16 (a) Informant Civilian Personnel Sect.
(b) Address Holabird Signal Depot, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-44 (month) (day) (year)
(c) Cemetery or crematory Wesley Cem.
Location Mt. Hamptstead, Md.

18 (a) Funeral director Durward A. Covington
(b) Address 21 W. 25th. Street, Balto., Md.

19 (a) FEB 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V8 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 February 1944, at 3:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Feb. 1944 to 9 Feb. 1944
and that I last saw h[illegible] alive on 9 Feb. 1944

Immediate cause of death: (a) Rupture of aortic aneurism.
Due to Unknown
Due to Unknown
Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation --
Major findings of operation
of autopsy: Awaiting Dr. Agrin.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible], Colonel, M. C.,
Station Hospital, SURGEON 2-9-1944
Address Holabird Signal Depot, Balto. 19, Md.

C. by: HOLMES

Please WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13884

70 #64814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30C

G 13884 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 23 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No home (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Hugh Turell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1884

8. AGE: Years	Months	Days	If less than one day
59	11	7	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Thompson
15. Birthplace Va.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (d) Funeral director Adolphus Halstead
(e) Address 1918 Druid Hill Ave.

FEB 9 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1944, at 6:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1923 to 2/3 1944.
and that I last saw him alive on 2/3 1944.

Immediate cause of death: Luetic meningitis; Duration ?
Due to Syphilis
Due to
Other Conditions Luetic aortitis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. F. Seyman M. D.
Address BCH Date signed 2/8

13885 G

BALTIMORE CITY HEALTH DEPARTMENT

AB-85182

CERTIFICATE OF DEATH

9/a

Registered No. G 13885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos-9days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Mackey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-5-1894

8. AGE: Years	Months	Days	If less than one day
49	5	2	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Odd jobs

11. Industry or business

FATHER
12. Name Henry Mackey
13. Birthplace N.C.

MOTHER
14. Maiden Name Jennie Deal
15. Birthplace N.C.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address RECORDS

17 (a) Burial (b) Date thereof Feb. 10, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Laura V. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 9 1944 (b) Huntington Williams, M.D.
(Filed by) (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 1944, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1943, to 2-7 1944, and that I last saw h[illegible] alive on 2-7 1944.

Immediate cause of death
Cerebral embolism — Duration 2 Weeks

Due to Bacterial Endocarditis

Due to

Other Conditions Non specific infections arthritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Hall M. D.

Address B.C.H. Date signed 2/9/44

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The [illegible] WITH UNFADING INK.

13886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C 13886

1a. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts.
(c) If hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Ailsa Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Hobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Eugene W. Hobson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 1873

8. AGE: Years	Months	Days	If less than one day
70	4	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Hannah Foxwell
15. Birthplace Maryland

16 (a) Informant Eugene W. Hobson
(b) Address 2818 Ailsa Ave

17 (a) Burial (b) Date thereof 2/10/44
(Burial, cremation, or removal) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) FEB 9 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 19 , at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1944 to Feb. 7, 1944, and that I last saw her alive on February 7, 1944.

	Duration
Immediate cause of death Cachexia	2 months
Due to Carcinoma of Cecum	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jan. 17, 1944
Major findings of operation: Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address University Hospital Date signed 2/7/44 M. D.

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 13887

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County
(c) City or town Jenkins
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 623
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leander Septon
3 (b) If veteran, name war
3 (c) Social Security Account No. 400-07-7576

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Easter
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Kentucky, Jenkins (town, county, and state)
10. Usual Occupation miner
11. Industry or business

MOTHER - FATHER
12. Name Isaac Septon
13. Birthplace Kentucky
14. Maiden Name Arametta Adams
15. Birthplace Kentucky

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory Jenkins Kentucky
Location Jenkins Kentucky
18 (a) Funeral director John A Mitchell & Sons
(b) Address 1200 Eutaw Place, Balto. Md.
19 (a) Date received by Registrar 2 9 1944 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1944 at 0 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1944 to Feb. 7 1944 and that I last saw him alive on Feb. 7 1944

Immediate cause of death Post-operative Hemorrhage of Duodenal ulcer

Duration

Due to Carcinoma of Esophagus in left cardiac region

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/3/44

Major findings of operation: Cancer area of Esophagus in left cardiac region

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Saunders
Address Johns Hopkins Hosp. Date signed 2/8/44

VS 150

I certify that the above is a correct copy of information shown on the original certificate of death filed with the Bureau of Vital Statistics, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 13888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

172

Registered No. C 13888

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bethlehem - Fairfield Corp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 McCabe ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (William J. Grob) WILLIAM JOSEPH GROB

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-01-1096

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Mildred Grob

6 (c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): Mar. 18, 1905

8. AGE: Years: 38 | Months: 10 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Tool Room

11. Industry or business: Bethlehem-Fairfield

FATHER
12. Name: William Joseph Grob
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Yetta Wolfe
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Mary M. Grob
(b) Address: 806 McCabe Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn Cemetery
Location: Baltimore County, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: North Ave. & Broadway

19 (a) [illegible] 1944 (b) [illegible] Registrar

FEB 9 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-7-1944, at 8:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Accidental Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-7-44 at 25/6 7.30 A M.
(b) Where did injury occur: Bethlehem-Fairfield Shipyard
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury: Found in the harbor, fell from ship.

23. Signature: Howard J. Mahoney M.D.
Medical Examiner.

Date signed 2-7-44

13889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 108

Registered No. C 13889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural Hall.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Harmon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Alice Harmon
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 1, 1872

8. AGE: Years	Months	Days	If less than one day
71	9	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Harman
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland.

16 (a) Informant Alice Harman
(b) Address Rose Hill, md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10/44 (month) (day) (year)
(c) Cemetery or crematory Oakes
Location Balto Co. Md.

18 (a) Funeral director Townsend & Donovan
(b) Address 3467 E. Baltimore St. for Hollander, Mgr.

FEB 9 - 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1944, at 10:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 1944, to — 19..
and that I last saw him alive on 2/7 1944.

Immediate cause of death	Duration
Lobar pneumonia	1 wk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Glenn O. Summerlin M. D.
Address University Hosp. Date signed 2/7/44

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

13890 BALTIMORE CITY HEALTH DEPARTMENT G 13890

CERTIFICATE OF DEATH 30E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 679 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Newman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer -

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Luther Brice
(b) Address 679 Vine St.

17 (a) Burial (b) Date thereof 2-10-44
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

19 Filed FEB 9 - 1944 Registered by Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1944 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1944 to Feb 7 1944. and that I last saw h. alive on Feb 7 1944.

Immediate cause of death Pulmonary congestion — Duration

Due to Cardiovascular disease

Due to Syphilis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation Autopsy — Aortic fusiform aneurism rupt.

of autopsy Coronal infarction, pleural effus.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. N. Carpenter M. D.
Address University Hospital Date signed 2/9/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 13891
Registered No.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 1519 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 S. Charles St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Ida Bloss

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband Joseph Bloss
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1865

8. AGE: Years	Months	Days	If less than one day
78	4	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name ? Dickson
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda ?
15. Birthplace Md.

16 (a) Informant Mrs. Walter F. Thompson
(b) Address 1519 S. Charles St. Balto. 23 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. A. Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Charles St (30)

19 (a) FEB 9 1944 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1944, at 4:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944, to Feb 8 1944, and that I last saw deceased alive on Feb 8 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	3 wk.
Due to	
Due to Glaucoma	2 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. K. Campbell
Address 16 W. Mosher St. Date signed 2/9/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G 13892 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1149 N. Carlton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 N. Carlton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma V. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles C Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1864

8. AGE: Years 79 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, or state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ezekiel Williams
13. Birthplace Md

MOTHER
14. Maiden Name Harriet Thomas
15. Birthplace Md

16 (a) Informant Charles C Smith
(b) Address 114 N. Carlton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3229 W. Edmondson Av.

19 (a) 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1944, at 3.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1943 to Feb. 6 1943 and that I last saw her alive on Feb. 5 1944

Immediate cause of death Chronic Cardio-renal disease — Duration about 3 mo.

Due to

Due to

Other Conditions Senile Changes
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Gaines M.D.

Address 655 W. Barre St Date signed 2/9/44

VS 180

G 13893 BALTIMORE CITY HEALTH DEPARTMENT G 13893
Registered No.

CERTIFICATE OF DEATH 194a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2033 S. Pulaski St.
(c) Hospital or institution: no

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME anna Carolina Ritter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George Ritter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25-1875

8. AGE: Years	Months	Days	If less than one day
68	11	12	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Casper Krempf
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Germany

16 (a) Informant George Ritter
(b) Address 203 S. Pulaski St.

17 (a) Burial (b) Date thereof Feb. 10-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) FEB 9 1944 (b) Certificate for Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5/ 1944, to 2/6/ 1944, and that I last saw h alive on 2/5/ 1944.

Immediate cause of death — Duration
Coronary Thrombosis — 1/2 hour
Due to Arteriosclerosis — 2
Due to
Other Conditions Probable fall - Bruises — 2
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cassard M. D.
Address 514 DRURY LANE Date signed 2/7/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 13894

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13894 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town College Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Kilgour

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife May Kilgour
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 2/4/80

8. AGE:	Years	Months	Days	If less than one day
W/80	64	-	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Univ. of Md.

FATHER
12. Name ? Kilgour
13. Birthplace Md

MOTHER
14. Maiden Name Annie Jones
15. Birthplace Md

16 (a) Informant May Kilgour
(b) Address College Park, Md

17 (a) Removal (b) Date thereof 2-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hyattsville
Location Hyattsville, Md

18 (a) Funeral director Francis Lowe & Sons
(b) Address Hyattsville, Md.

19 (a) 1944 (b) Huntington Williams M.D.
(Date received by registrar) (Signature)

VS 8

MEDICAL CERTIFICATION.

20. DATE OF DEATH Feb. 9 1944, at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1944 to 2-9 1944, and that I last saw him alive on 2-9 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Bilateral Lobar pneumonia	
Due to	
Other Conditions Arteriosclerotic C-V disease	

(Include pregnancy within 3 months of death.)

Date of operation
Major findings of operations
of autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. M. Jones Jr.
Address Univ. Hosp. Date signed 2-9-44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13895 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Jan. 27, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) 1 month

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1925 Eutaw Place, Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Eutaw Place, Balto., Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL MARSH

3 (b) If veteran, name war -

3 (c) Social Security Account No. 216-12-7851

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife ~~MRS~~ Lydia Stevenson

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1890

8. AGE: Years 53 | Months 4 | Days 24 23 | If less than one day hr. min.

9. Birthplace Glenwood Springs, Colo. (Town, county, and state)

10. Usual Occupation Fireman (Merchant Seaman)

11. Industry or business "

FATHER
12. Name Charles Marsh
13. Birthplace ?

MOTHER
14. Maiden Name Hattie ?
15. Birthplace ?

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-44 (month) (day) (year)
(c) Cemetery or crematory St Mary's (Hampden)
Location Roland Ave.

18 (a) Funeral director R. Lee Ades
(b) Address 4644 York Rd

FEB 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1944 at 4:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27, 1944 to Feb. 6, 1944 and that I last saw him alive on Feb. 6 1944

Immediate cause of death Bilateral lobar pneumonia

Duration Unknown, but had cold since Jan. 14, '44

~~MRS~~

Due to Toxic myocarditis & hepatitis

Duration Unk.

Other Conditions --

(Include pregnancy within 3 months of death)

Date of operation None done

Major findings of operation: None

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address Baltimore, Md. Date signed 2/7/44 M.D.

MS-50680

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13896 Registered No. 52c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Driveway and 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo13da
(e) Length of stay in Baltimore (yrs., mos., or days) 6mo13da

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Naudain Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELUE SAMUEL FACEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	228-18-9606

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	col.	Married

6 (b) Name of husband or wife Roberta Raven
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1888

8. AGE: Years	Months	Days	If less than one day
55	8	14	hr. min.

9. Birthplace Jamaica, B.W.I. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business

FATHER
12. Name Alfred Facey
13. Birthplace Jamaica, BWI

MOTHER
14. Maiden Name Darlene Hutchinson
15. Birthplace Jamaica, BWI

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Loudon Park

18 (a) Funeral director A Lee Ofel
(b) Address 4644 York Rd.

19 (a) Date received FEB 9 1944 (b) Registrar Washington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1944 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25, 1943 to Feb. 7, 1944, and that I last saw him alive on Feb. 7, 1944.

Immediate cause of death: Carcinoma of urethra with generalized metastases — Duration: Unk.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 12/3/43
Major findings of operation: Cystoccopy in suprapubic sinus with biopsy of bladder
Findings of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. S. Black, M. D.
Address U. S. Marine Hospital, Baltimore, Maryland. Date signed 2/8/44

Marge 13897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 13897

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Lower Stret (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eunice Lewis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 7 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 7 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1944 at 6 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid & subdural hemorrhage

Due to Ruptured aneurysm of anterior cerebral artery

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed January 21, 1944

0721 By Howard L. Steele, M. D.

G 13898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 Northern Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Gorsuch Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie A. Nauman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Louis S. Nauman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3rd 1890

8. AGE: Years 53 Months 1 Days 5 If less than one day hr min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Henry F. Mordecai
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah A. Donovan
15. Birthplace Del.

16 (a) Informant Louis S. Nauman
(b) Address 935 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 Filed Feb 9 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7th 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1942 to Feb. 7, 1944. and that I last saw h~~er~~ alive on Feb. 6 1944.

Immediate cause of death Coronary Thrombosis.

Due to Thyrotoxic Cardiovascular Renal Disease

Duration: 3 yrs.

Due to

Other Conditions Thyroidectomy

(Include pregnancy within 3 months of death)

Date of operation Sept. 1942.

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Wolfe

Address 1331 Chatsworth Ave Date signed 2-8-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13899 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 N. Dallas St.
(c) Hospital or institution:
4-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 N. Dallas Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lilla V. Cyrus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1875

8. AGE: Years 68 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Thomas
13. Birthplace Va.

MOTHER
14. Maiden Name Kitty Mullen
15. Birthplace Va.

16 (a) Informant Esther Isaacs
(b) Address 904 Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. R. A. Elmo's Dft.
(b) Address 1124 N. Carlton St.

19 (a) (Date rec'd by registrar) (b) Thos. J. Williams M.D. Registrar

FEB 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1944, at 7:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1943 to Feb 6 1944 and that I last saw her alive on Feb 6 1944

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Cardio renal Disease

Due to

Other Conditions Muscular atrophy of the thigh
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Adele A. Lefevre

Address 822 N. Bond St Date signed 2/9/44

Correct age is especially important. If uncertain, please write the causes of death clearly and legibly.

G 13900 Buchheister

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 13900 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4328 Shamrock Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 50 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4328 Shamrock Av
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Buchheister

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Jacob Henry Buchheister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 1871

8. AGE: Years	Months	Days	If less than one day
72	6	21	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace Germany
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Edward Buchheister
(b) Address 4328 Shamrock

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 3202 Harford Road

19 (a) FEB 9 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1944, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 8 1944 to Feby 8 1944 and that I last saw her alive on Feb 7 1944

Immediate cause of death: Pneumonia — Duration 3 D.

Due to Acute Hypostatic Pneumonia — Duration 2 D.

Due to Chr. Interstitial Nephritis — Duration 1 Mo

Other Conditions Pernicious Anemia — Duration 2 Yrs

Arteriosclerosis & Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. O. Stearns M. D.
Address 2878 Harford Rd Date signed 2-9-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

Registered No. G 13901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 S. Wolfe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wlodarczyk

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER
12. Name Jan Paprota
13. Birthplace Poland

MOTHER
14. Maiden Name Denk.
15. Birthplace Poland

16 (a) Informant Margaret Helewicz
(b) Address 110 S Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

FEB 10 1944 (Date received) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1944, at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944 to Feb 9 1944 and that I last saw h[illegible] alive on Feb 9 1944

Immediate cause of death CARCINOMA OF STOMACH — Duration 2 YRS.

Due to

Due to

Other Conditions GENERALIZED ARTERIOSCLEROSIS — Duration ??
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F. Dunga, M.D.
Address 2098 Clarks St. Date signed 2/9/44

correct age is especially important. Physicians, please write all figures and words clearly and legibly.

G 13902 G 13902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3609 Greenmount
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3609 Greenmount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Huffman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widowed

6 (b) Name of husband or wife Charles M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9-1889

8. AGE: Years	Months	Days	If less than one day
54	3	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Chief Clerk
11. Industry or business

FATHER
12. Name James Feeney
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Kerr
15. Birthplace Ireland

16 (a) Informant Mr. Umbert Pisani
(b) Address 704 S. Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director George D. Rusk
(b) Address 5305 Harford Rd.

19 (a) FEB 9 1944 (Date rec'd by registrar) (b) Huntington Hollins Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1940 to Feb 7 1944 and that I last saw h alive on Feb 7 1944.

Immediate cause of death
Arteriosclerosis — Duration 1945
Chron Myocarditis — 1941
Due to Chron Interstitial Nephritis — 1941
Due to
Other Conditions Arter. cardiac debilitation — 1941

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. W. Bishop M. D.
Address 501 S Linden Av Date signed Feb 8

BISHOP

G 13903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13903

Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Dr. and 31st St.
(c) Hospital or institution:
U.S. Marine Hospital, Baltimore, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2/3/44
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 White Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Emery

3 (b) If veteran, name war PTE

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret R.

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1886

8. AGE: Years 57 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Howard County, Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Charles Emery
13. Birthplace ? MH

MOTHER
14. Maiden Name Louise Ridgely
15. Birthplace Howard County, Md.

16 (a) Informant Margaret R. Emery
(b) Address 3107 White Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-44 (month) (day) (year)
(c) Cemetery or crematory Parkview
Location Balto

18 (a) Funeral director Leonard Myers
(b) Address 1702 Hanford Rd

19 (a) FEB 9 - 1944 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1944 at 10-A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3, 1944 to Feb. 9 1944 and that I last saw him alive on Feb. 9 1944.

Immediate cause of death Lobar pneu. rt. lung — Duration unknown

Congestive heart failure

Due to toxic myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Arehart M. D.

Address US Marine Hospital, Baltimore, Md. Date signed Feb. 9, 1944

Physicians: please write the causes of death clearly and legibly. Do not use abbreviations or ditto marks.

G 13904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G 13904 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3339 Elmora Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Robert Lee Starkey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30-1944

8. AGE: Years	Months	Days	If less than one day
		11	hr. min.

9. Birthplace Balto md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Vernon R
13. Birthplace md

MOTHER
14. Maiden Name Evelyn M Fruth
15. Birthplace Md

16 (a) Informant Vernon R Starkey
(b) Address 3339 Elmora av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cedar
Location Balto Co Md

18 (a) Funeral director Leonard Rush
(b) Address 1205 Hartford Rd

19 (a) (Date rec'd by registrar) (b) Washington for Hoffman Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1944, at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 9 1944, and that I last saw h alive on Feb. 9 1944.

Immediate cause of death Diarrhea - Etiology un determined — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas O Brennan M. D.
Address St Joseph's Hosp. Date signed 2-7-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 13905 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Willow & Eutaw Live.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. - 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Warden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey L. Winfrey
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-01-8474

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Gladys Winfrey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 1896

8. AGE: Years 47 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace N. Carolina (Town, county and state)
10. Usual Occupation Carpenter
11. Industry or business Civil Construction Co

FATHER
12. Name John R. Winfrey
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Minnie Murdock
15. Birthplace N. Carolina

16 (a) Informant Gladys Winfrey
(b) Address 1009 Warden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Balto., Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St. Paul St.

FEB 10 1944
Date received by local registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1944 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1944 to 2/9 1944.
and that I last saw h[illegible] alive on 2/9 1944.

Immediate cause of death Coronary Occlusion
Due to Myocardial Infarct.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryon M.D.
Address St. Agnes Hospital Date signed 2/9/44

Please write plainly, with pen or pencil. Do not use ink of a color that will not photograph. Use no abbreviations except M.D. Do not leave any blanks; if the information cannot be obtained, write "unknown" or "none." Physicians: please write the causes of death clearly and legibly. Be sure that the statements of time, place, and cause of death are correct and complete. Be sure that the age is especially important.

13906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13906 Registered No.

171a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4923 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Daniel Parks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1876

8. AGE: Years: 67 | Months: 2 3 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Pavement Contractor

11. Industry or business: Self

FATHER
12. Name: James H Parks
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Curtis
15. Birthplace: Virginia

16 (a) Informant: Mrs. Eva L. Parks
(b) Address: 4923 Park Heights Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) FEB 10 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1944 at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27-17 P.
(a) Date of injury February 7, 1944 7:52 P.M.
(b) Where did injury occur? Park Heights Ave. & Spaulding Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Parkway Barn While at work? No
(d) Means of injury Struck by street car

23. Signature Robert Lee Statham M.D.
Medical Examiner.
Date signed February 8, 1944

VS 151

G 13907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13907 Registered No. 13/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 Laurens Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1854

8. AGE: Years 90yrs. Months Days If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Estella Smith
(b) Address 1429 Laurens Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Balto. City

18 (a) Funeral director Charles R. Law
(b) Address 802-4 Madison Avenue

19 (Date rec'd by registrar) FEB 10 1944 Livingston Williams, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-1944, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-1944, to 2-8-1944, and that I last saw h[illegible] alive on 2-5-1944.

Immediate cause of death Chronic Cardiovascular Renal disease
Due to Senility

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. J. Jackson
Address 600 Washington Ave. Date signed 2/9/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13908 Registered No. 128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 George St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 George (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard D. Brent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Lizzie Brent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6-1880

8. AGE: Years 63 | Months 9 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Messenger

11. Industry or business Standard Oil

FATHER 12. Name Delany Brent

13. Birthplace Md

MOTHER 14. Maiden Name Charlotte A. Jones

15. Birthplace Md

16 (a) Informant Lizzie Brent

(b) Address 806 George St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location C. A. 69

18 (a) Funeral director Samuel H. Chase Sons

(b) Address 608 N. Gilmor St

FEB 10 1944 (Date rec'd by registrar) Hunting for Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1944 at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1939 to Feb 7 1944 and that I last saw h — alive on Feb 7 1944

Immediate cause of death Pulmonary Tuberculosis — Duration 3 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irene DeFlaviano M. D.

Address 2329 Joseph St Date signed Feb 8 1944

correct age is especially important when deceased is a child under 5 years

13909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13909
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 948 Abbott Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 948 Abbott Court
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Matt T. Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edith Snyder Perkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1-1871

8. AGE: Years 72 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Executive (Retired)

11. Industry or business Public school

FATHER
12. Name William W. Perkins
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah E. Christus
15. Birthplace Unknown

16 (a) Informant Mrs. Edith S. Perkins
(b) Address 948 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Geo. L. Boyer Jr
(b) Address 512 Hollins St

FEB 10 1944 (Date rec'd) Huntington Hollins (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1944 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Feb. 7 1944 and that I last saw h[illegible] alive on Feb 6 1944

Immediate cause of death Chronic Myocarditis — Duration 5 yrs

Due to arteriosclerosis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Swab, M. D.
Address 101 W. Read St Date signed 2-8-44

correct age is especially important. If unknown, give approximate age by years, months, days, or hours.

VS 250

13910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195E

Registered No. G 13910

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8107 Old Philadelphia Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin Kriedenkoff (KRIDENOFF)

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-4786

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-18-1926

8. AGE: Years	Months	Days	If less than one day
17	5	921	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Bus driver
11. Industry or business Rosedale Bus, Co.

FATHER
12. Name Jesse C. Kridenoff
13. Birthplace Penna

MOTHER
14. Maiden Name Lillian S. Hammerbacher
15. Birthplace Penna

16 (a) Informant Parents
(b) Address 8107 Old Phila Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12-1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd.

18 (a) Funeral director John J. Connelly
(b) Address 448 Eastern Ave

19 (a) FEB 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1944, at 12:40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-8-44 at 12:20 P.M.
(b) Where did injury occur? 8030 Philadelphia Rd. Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial. While at work? Yes.
(d) Means of injury Hit on the head by two tires

23. Signature H. L. Williams M.D. Medical Examiner.
Date signed 2-9-44.

steel Jack

VS 151

G 13911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c ✓

Registered No. G 13911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 W. North Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME HANNAH SCHERR

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Meyer Scherr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 22, 1874

8. AGE: Years	Months	Days	If less than one day
69	9	16 17	hr. min.

9. Birthplace Madison, N.J.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Windesheim,
13. Birthplace Germany.

MOTHER
14. Maiden Name Julia Lehman,
15. Birthplace Germany.

16 (a) Informant Mr. Wilhiam Scherr,
(b) Address 800 W. North Ave.

17 (a) Burial (b) Date thereof 2/ 11/44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.
18 (a) Funeral director Harris Levering & Sons
(b) Address 1902 Eutaw Place.
19 (a) 2-13-1944 (b) Huntington Williams, Myd
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8th. 1944 at 11:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1943 to Feb 7 1944.
and that I last saw h[er] alive on Feb 7 1944.

Immediate cause of death	Duration
Cardiac Decompensation	4 days
Due to Genral arteriosclerosis	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius F. Friedman M. D.
Address 6 E. Biddle St. Date signed

VS 2

13912 T. F. Hawkins 1 E. Randall St So 9/10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No. G 13912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 St. Paul St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maud Nayne

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-0230

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Jan 13th 1883

8. AGE: Years 61 | Months 0 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business Cont'l Life Ins. Co.

FATHER
12. Name Sadie Nayne
13. Birthplace Marlboro

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr Dukes
(b) Address Cont'l Life Ins. Co.

17 (a) Cremation (b) Date thereof 2/10/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Mount
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

FEB 10 1944 Huntington Williams, Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1944, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944 to Feb 8 1944 and that I last saw her alive on Feb 7 1944

Immediate cause of death
Cerebral Hemorrhage — Duration 2 days

Due to Hypertension — 2 Mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. F. Hawkins

Address 1 E. Randall St Date signed 2/10/44 M. D.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

13913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 13913
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 E.Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 E.Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Calvin Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 1941

8. AGE: Years	Months	Days	If less than one day
2	2	12	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard E.Carter
13. Birthplace Alexandria Va

MOTHER
14. Maiden Name Thelma E.Kipp
15. Birthplace Baltimore Md

16 (a) Informant Howard E.Carter
(b) Address 2101 E.Lafayette Ave

17 (a) Burial (b) Date thereof Feb 12 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore Md

18 (a) Funeral director Harry H. Hancock
(b) Address 4204 Ridgewood Ave

(a) FEB 10 1944 (b) Thurlington Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1944 to 2/9 1944 and that I last saw h[illegible] alive on 2/9/44

Immediate cause of death
Asphyxia
Due to Aspiration of vomitus
Due to
Other Conditions R.L.C. Broncho-pneumonia
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis E. Reynolds M.D.
Address 700 N. Pat. PK. Ave Date signed 2/10/44

correct age is especially important when child is under one year.

13914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

Registered No. G 13914

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2409 E Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 2409 E. Hoffman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Elizabeth Paulus
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Frank M. Paulus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17 1883

8. AGE: Years 60 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business Apt House

FATHER
12. Name John G. Moller
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Lawrence G. Moller
(b) Address 2314 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road - Balto Md

18 (a) Funeral director John A Miller Jr
(b) Address 2435 E Oliver St

19 (a) FEB 10 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1943 to Feb 9 1944
and that I last saw her alive on Feb 8 1944

Immediate cause of death Cardiac Dilatation — Duration 1 Day

Due to Hypertension — 1 year

Due to Arteriosclerosis — 3 mos

Other Conditions Contributing

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Greenberg M. D.
Address 502 S Ehrnt St Date signed 2/10/44

Please write the name of death clearly and legibly. Physician: please write the cause of death correctly and legibly. Information as to correct age is especially important.

G 13915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13915
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Community Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Wash. Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Sansone

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no
4. Sex: male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: mar.
6 (b) Name of husband or wife: Bessie L. Sansone
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/24/[illegible]
8. AGE: Years 46 Months 11 Days 14 If less than one day hr. min.
9. Birthplace Washington D. C. (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business
12. FATHER Name Liberato Sansone
13. Birthplace Italy
14. MOTHER Maiden Name Josephine Perricone
15. Birthplace Italy
16 (a) Informant Bessie L. Sansone (Wife)
(b) Address 520 Washington Blvd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Location Belgin Rd. Balt. Md.
18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.
19 (d) FEB 10 1944 [illegible] Huntington Ave. Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1944, at 1:55 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1944 to Feb 8 1944 and that I last saw him alive on Feb 8 1944

Immediate cause of death: Cardiac failure — Duration
Due to: Pneumonia
Due to: Possible [illegible] septicemia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Alma H Hourigan M. D.
Address Date signed

VS 8

G 13916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

49a

G 13916
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2817 Rueckert Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Rueckert Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maytert Mary Elizabeth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married.

6 (b) Name of husband or wife Maytert John 6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Mar 9th 1869

8. AGE: Years	Months	Days	If less than one day
74	11	-	hr. min.

9. Birthplace Balto. Co. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hutton John
13. Birthplace Balto. Co

MOTHER
14. Maiden Name Goodwin Katherine
15. Birthplace Balto. Co

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Geo W Sahilling & Son
(b) Address 3624 Greenmount Ave

19 (a) (b)
(Date received by registrar) (Registrar)

FEB 10 1944

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9th 1944, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1943 to Feb 9th 1944, and that I last saw her alive on Feb 8 1944.

Immediate cause of death: Edema - Coronary Thrombosis Left Coronary Artery — Duration 1 1/2 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-7-43

Major findings of operation: Edema - Coronary Thrombosis Left Coronary Artery

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature K. L. Cosby M.D.

Address 5106 Harford Rd Date signed 2-9-44

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 13917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 13917 Registered No. 163H

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 638 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Southworth

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Eugene W. Southworth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1915

8. AGE: Years	Months	Days	If less than one day
29	—	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name Robert L. Young
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Laura Christian
15. Birthplace Baltimore

16 (a) Informant Mrs. Catherine Lanzone
(b) Address 1522 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Sadzyeck & Cole
(b) Address 1209 W. Lombard St.

19 (a) 2-10-1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1944, at 10:40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to Suicide

Other Conditions Mental depondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-8-44 at M.
(b) Where did injury occur? Above address
(c) Did injury occur at home, on farm, industrial place, in public place? hotel While at work? no
(d) Means of injury Gas from kitchen stove

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 2-9-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 13918 µ W

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 13918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospt.
(c) Hospital or institution: Same
(d) Length of stay in hospital or inst. (yrs., mos., or days) 114da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County C
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Huntington ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country C

3 (a) FULL NAME Charles Fritzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Maude E.
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Oct 20 - 1904

8. AGE: Years	Months	Days	If less than one day
39	3	19	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Chas. E. Fritzel
13. Birthplace Md

MOTHER
14. Maiden Name Nellie Reeves
15. Birthplace Md

16 (a) Informant wife Maude E.
(b) Address 2618 Huntington ave

17 (a) Burial (b) Date thereof Dec 11-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Govt. ave.

18 (a) Funeral director John A. Moran
(b) Address 3002 E. Baltimore

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1944 at 2100 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1944 to Dec 6 1944 and that I last saw h[illegible] alive on Dec 6 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Emaciation & Pneumonia	
Due to Stricture of Colon & Dig Tumors	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept 15, 1943
Major findings of operations Tumor and Stricture of colon.
of autopsy Pneumonia, bronchial

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9/15/43 at 6 P. M
(c) Where did injury occur? Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Thomas L. Martin While at work? Yes
(Specify type of place)
(e) Means of injury Fall from scaffold

23. Signature M. Edwin Jr. Landstein M. D.
Address University Hospt. Date signed 12/7

VS 8

H. L. Wallenmeyer MD Lit Medical Examiner

G 13919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 13919

Registered No. 3628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 74yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 N. Stricker St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Della Sherrod

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	Married

6 (b) Name of husband or wife Wm. Sherrod
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Nov 1899

8. AGE: Years	Months	Days	If less than one day
44	3		hr. min.

9. Birthplace Robinsonville N. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Own home

FATHER
12. Name Louis Robinson
13. Birthplace Robinsonville N.C.

MOTHER
14. Maiden Name Martha Anders
15. Birthplace N. C.

16 (a) Informant Wm. Sherrod
(b) Address 902 Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10-44 (month) (day) (year)
(c) Cemetery or crematory Rocky Mount N.C.
Location

18 (a) Funeral director Mrs. Katie D. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Signature) (b) Kingston Williams (Address)

FEB 10 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7-1944, at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5-1944, to 2-7-1944, and that I last saw her alive on 2-6-1944.

Immediate cause of death: Cerebral hemorrhage — Duration: 3 days
Due to: Hypertension and arteriosclerosis
Due to:
Other Conditions: Unknown
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 2-8-44

G 13920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 13920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 331 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Henson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1892

8. AGE: Years	Months	Days	If less than one day
51	7	13	hr. min.

9. Birthplace Simpsonville, Howard Co. Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Joshua Henson
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Laura Bruce
15. Birthplace Howard Co. Md.

16 (a) Informant Joshua Henson
(b) Address Simpsonville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12-44 (month) (day) (year)
(c) Cemetery or crematory Simpsonville Md
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Calhoun St.

19 (a) (Date received by registrar) (b) Registrar

B 1 10-1944

VS 188

MEDICAL CERTIFICATION

32

20. DATE OF DEATH Feb. 8 1944, at 5 9. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944 to Feb 8 1944, and that I last saw her alive on Feb 8 1944.

Immediate cause of death Toxemia due To Diabetic Gangrene of Rt. Foot; Ischiorectal Abscess — Duration

Due to

Due to Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/2/44

Major findings of operations: Ischio-Rectal Abscess

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. L. Banfill M.D.
Address Provident Hosp. Date signed 2-8-44

Morgue G 13921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13921 Registered No. 1147a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S. Greene St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Hawthorne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
51	50		hr. min.

9. Birthplace Drures S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Clarence Hawthorne
13. Birthplace Druses S. C.

MOTHER
14. Maiden Name Mattie McCourt
15. Birthplace N. C.

16 (a) Informant Mattie Hawthorne
(b) Address 2632 Webster St. Pittsburg Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10-1944 (month) (day) (year)
(c) Cemetery or crematory
Location Pittsburg Pa.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 8 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1944, at 5:12 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Dec. death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Silicosis of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Feather M.D. Medical Examiner.
Date signed February 8, 1944

Correct age in expressions. Physicians, please write the causes of death clearly and legibly.

G 13922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13922 Registered No. 108

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Perlight

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	M

6 (b) Name of husband or wife Willie Mae Perlight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1900

8. AGE: Years	Months	Days	If less than one day
43	10	23	hr. min.

9. Birthplace Vidalia Ga. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Willie Mae Perlight
(b) Address 1021 W. Lanvale St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof F.E. 12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location
18 (a) Funeral director Mrs Katie R. Williams
(b) Address 922 N. Schroeder St.
FEB 10 1944 (b) Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1944 at 5-35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1944 to Feb 8 1944, and that I last saw him alive on Feb 8 1944.

Immediate cause of death	Duration
Lobar Pneumonia	3 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. L. Banfield M. D.
Address Provident Hospital Date signed 2-8-44

G 13923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

G 13923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Woodbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emil Horn (EMIL HORN)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-5297

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Meta Horn
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Aug 20 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66	5	20		

9. Birthplace Frankfurt Germany (Town, County and State)
10. Usual Occupation Upholsterer
11. Industry or business

FATHER
12. Name Levy Horn
13. Birthplace Germany

MOTHER
14. Maiden Name Babette Schnaberger
15. Birthplace Germany

16 (a) Informant Sonya Horn
(b) Address 2426 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 1944 (month) (day) (year)
(c) Cemetery or crematory Jewish Friendship
Location Balto. & Baltimore Co.

18 (a) Funeral director J. Rhans & Co
(b) Address 2433 Eastern Ave

19 (a) (Date received) FEB 10 1944 (b) Huntington Wilson Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/ 1944 at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1944 to Feb 9 1944
and that I last saw him alive on Feb 9 1944

Immediate cause of death Pneumonia — Duration 10 days

Due to

Due to Congestive heart failure — 4 mo

Other Conditions — over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

If autopsy: aortic stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Lillon
Address Sinai Hosp Date signed Feb 9, 1944 M. D.

Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The correct age is especially important.

13924 — L- 85563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13924 — Registered No. 13B

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Collington Ave. (If rural give location) 12th N. East Ln
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Zellers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife Anna Zellers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1892

8. AGE: Years	Months	Days	If less than one day
51	1	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Orderly
11. Industry or business John's Hopkins Hospital

FATHER
12. Name William Zeller
13. Birthplace Md.

MOTHER
14. Maiden Name Bernard ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto., Md.

18 (a) Funeral director William Cook - Inc
(b) Address 217 St. Paul St. Huntington Williams, Mgr.

19 (c) Date received by Local Registrar FEB 11 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1944, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22 1943 to 2-8 1944 and that I last saw h[illegible] alive on 2-8 1944.

Immediate cause of death: Pulmonary TB

Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. [redacted] was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mell

Address B. C. H. Date signed 2/9/44 (M. D.)

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$7 ✓

Registered No. G 13925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-16
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4517 Homer Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Salaman Globus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	W.	M

6 (b) Name of husband or wife Dora Globus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Restaurant

FATHER — 12. Name Hyman Globus
13. Birthplace Russia

MOTHER — 14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Ralph Globus
(b) Address 3411 Royce ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11/44 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew Cem't.
Location Blair Road

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 N. North ave

FEB 11 1944 (b) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1944 at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1944 to 2/9 1944, and that I last saw h[illegible] alive on 2/9 1944.

Immediate cause of death Respiratory — Duration

Due to Bulbar palsy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Akman M. D.
Address Sinai Hosp. Date signed 2/9/44

Except ages, which UNKNOWN must be stated, every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. C 13926

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1221 N. Carrollton Ave

(c) Hospital or institution: N.M. Carroll, Aged Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1221 N. Carrollton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Daniel Smith

13. Birthplace Md

MOTHER 14. Maiden Name Henrietta Butler

15. Birthplace Md

16 (a) Informant Mrs Rosa Stewart

(b) Address 1221 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore, Md

18 (a) Funeral director Mrs Frances A. Hemsley

(b) Address 718 W. Biddle St.

19 FEB 11 1944 (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1944 at 7 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1944 to Feb. 10 1944. and that I last saw h[illegible] alive on Feb 10 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 4 days

Due to Hypertension and Cardiovascular disease

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ralph W. Redding Jr

Address 426 W. Gilmor St Date signed 2/11/44

VS 186

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13927 LOLA GROSS ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G 13927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 538 W. Preston
(b) Street address Lola Gross
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 538 W. Preston St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lola Gross

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
fem	colored	married

6 (b) Name of husband or wife Benj. Gross
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 12-11-99

8. AGE: Years	Months	Days	If less than one day
44	1 mo	28	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business Housework

FATHER
12. Name Charles Hodges
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Georgianna Hodges
15. Birthplace Baltimore Md

16 (a) Informant Benj. Gross
(b) Address 538 W. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md.

18 (a) Funeral director Mc Francis A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) FEB 17 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9, 1944 at 9:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7, 1943, to Feb 9, 1944, and that I last saw h[illegible] alive on Feb 9, 1944.

Immediate cause of death Hemorrhage, death occurred on about 5 minutes Feb 9 1944. — Duration 5 minutes
Due to Bronchitis following Influenza
Due to Cold conditions from insufficient heat
Other Conditions Insufficient food for a normal diet
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lorenzo B. Tevons M. D.
Address 426 N. Greene St Date signed

VS 3

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13928 LeRoux ✓ G 13928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 3rd
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1043 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bella Le Roux

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Sarah Carrol Le Roux
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4 - 1874

8. AGE: Years	Months	Days	If less than one day
70	1	6	hr. min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation Shipbuilder
11. Industry or business

FATHER
12. Name Paul Le Roux
13. Birthplace Canada

MOTHER
14. Maiden Name Edaze Trottier
15. Birthplace Canada

16 (a) Informant Edward A. Le Roux
(b) Address 20 - 2nd St. Albany N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/11/44 (month) (day) (year)
(c) Cemetery or crematory St. Agnes Cemetery
Location Albany N.Y.

18 (a) Funeral director Elizabeth Hartline Inc.
(b) Address 1756 West St.

19 (a) FEB 11 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10-44 19 , at 3 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1944 to 2-10 1944 and that I last saw h IM alive on 2-10 1944.

Immediate cause of death	Duration
Hypertensive Cardio vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles E. Woodruff M. D.
Address 1213 Light St Date signed 2-10-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13929

Registered No. 91a (6a)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Redwood
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Edgewood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Lantz

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-8585

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Blanche Lantz
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug 19 1886

8. AGE: Years	Months	Days	If less than one day
57	5	20	____ hr. ____ min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Machinist (Helper)
11. Industry or business U.S. Govt

FATHER
12. Name Frederick Lantz
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucy Hanson
15. Birthplace Maryland

16 (a) Informant Mrs. Blanche Lantz
(b) Address Edgewood, Md.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Feb 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran
Location Joppa, Md.

18 (a) Funeral director H. K. McComas & Sons
(b) Address Abingdon, Md.

FEB 11 1944 (Date received by Registrar) Lexington Williams M.D. (Registrar)

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1944, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1944, to Feb 9 1944, and that I last saw him alive on 2/9 1944.

Immediate cause of death Not determined - fever - cerebral accident - apoplexy?

	Duration
Due to Subacute bacterial endocarditis	1
Due to	
Other Conditions Pneumonia, lagar	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Kemper M. D.
Address University Hospital **Date signed** 2/9

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 13930 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Tobey Tobey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John C Tobey
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Aug 29 - 1883
8. AGE: Years 60 Months 0 Days 10 If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Sam Taylor
13. Birthplace Balto

MOTHER
14. Maiden Name Alice Sunderland
15. Birthplace Balto

16 (a) Informant John C Tobey
(b) Address 1031 N Washington
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location City
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E Oliver St
19 (a) FEB 11 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1944 at 4 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944 to Feb 8 1944. and that I last saw h[illegible] alive on Feb. 8 1944.

Immediate cause of death: Cerebral hemorrhage
Due to: Hypertensive cardio-vascular disease
Due to:
Other Conditions: Lobar pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Christian J. Rechter M.D.
Address St. Joseph's Hosp. Date signed 2/10/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 13931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

G 13931 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 E. Lafayette Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Barbara Kleeg
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1944

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Leo. Kleeg
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Dorothy Seigmund
15. Birthplace Baltimore Md.

16 (a) Informant Joseph C. O'Melia
(b) Address 1729 E. Lafayette Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/11/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Nelson St

19 Filed FEB 11 1944 (Date rec'd by Registrar) (b) Registrar Huntington Hitt

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1944, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1944 to Feb 10 1944, and that I last saw h[illegible] alive on Feb 10 1944.

Immediate cause of death Diarrhea of newborn

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St. Joseph Hospital Date signed 2-10-44

G 13932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G 13932

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 N Montford Ave
(c) Hospital or institution:

8-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 N Montford (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie E Fink

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Charles Fink
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) April 18, 1875

8. AGE: Years	Months	Days	If less than one day
68	9	22	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Peter Otto
13. Birthplace Balto

MOTHER
14. Maiden Name Annie Pilitt
15. Birthplace Balto

16 (a) Informant Charles Fink
(b) Address 1708 N Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

FEB 11 1944 (b) Huntington Williams Asst.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/44 19 . at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1937 to Feb 9 1944. and that I last saw her alive on Feb 9 1944.

Immediate cause of death	Duration
Pneumonic Heart Disease	7 hrs.
Due to Myocardial Infarct	2 yrs
Due to Diabetes Mellitus	2 yrs
Other Conditions Pernicious Anem.	20 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm E Kemp MD
Address 156 N Milton Ave Date signed 2/10/44

156 N. Milton Ave.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 119a

Registered No. G 13933

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital 6 ✓ 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 E. FAIRMOUNT AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Baby Zeigler
3 (b) If veteran, name war NO
3 (c) Social Security Account No. NONE
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. SINGLE
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JAN. 30 1944
8. AGE: Years | Months | Days 10 | If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name FREDERICK ZEIGLER
13. Birthplace MICH.

MOTHER
14. Maiden Name FLORENCE GARRETT
15. Birthplace N.J.

16 (a) Informant FLORENCE ZEIGLER (MOTHER)
(b) Address 1817 E. FAIRMOUNT AVE.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 11/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD
18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.
19 (a) FEB 11 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1944 at 10 05 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1944 to Feb 9 1944 and that I last saw h/ alive on Feb 9 1944
Immediate cause of death Diarrhea of Newborn — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at. M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Brennan M. D.
Address St. Joseph Hospital Date signed 2-9-44

VS 250

13934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13934
Registered No.

131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Homewood Avenue
(c) Hospital or institution:

10-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Homewood Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Robert E. L. McCoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Estelle Keller
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) [illegible] 1886
8. AGE: Years: About 58 | Months | Days | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (town, county, and state)
10. Usual Occupation: Tailor
11. Industry or business

FATHER
12. Name: John L. McCoy
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Lilly Agnes Sharf
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Robert E. L. McCoy
(b) Address: 1216 Homewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: Mc. W. Means & Son
(b) Address: 805 N. Calvert Street

FEB 11 1944
(Date rec'd by registrar)
(b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1944, at 11 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1943 to Feb 8 1944, and that I last saw h[illegible] alive on Feb 8 1944

Immediate cause of death: Acute cardiac failure — Duration
Due to: Ch. Nephritis
Due to: Bronchial asthma
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: C. L. Hamstead M. D.
Address 733 Aisquith St Date signed 2/11/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

13935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 13935

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2030 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Kirk

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Wm. H. Kirk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7, 1874

8. AGE: Years 69 | Months 2 | Days 3 | If less than one day: hr. min.

9. Birthplace Maryland (Queen Ann, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Lane
13. Birthplace Md.

MOTHER
14. Maiden Name Alice V.
15. Birthplace

16 (a) Informant Daughter, Mrs. Grace Jackson
(b) Address Liberty Road, Randallstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 11 1944 (Date rec'd by registrar) (b) H. Livingston Williams III (Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1944, at 10:38 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1944 to 2-10 1944, and that I last saw her alive on 2-10 1944.

Immediate cause of death Left pulmonary hemorrhage — Duration

Due to Dyspraxia or abscess

Due to

Other Conditions Diabetis inf. for spleenic abscesses, diabetis mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Left pul. hemorrhage - splenic abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Baldwin M. D.
Address W. B. G. H. Date signed 2/10/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13936
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3904 Callaway Ave.
(c) Hospital or institution:

15-11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Callaway Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MINNIE E. KOHLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jacob G. Kohler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1867

8. AGE: Years	Months	Days	If less than one day
77	1	1	hr. min.

9. Birthplace Newark, N. J. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Condon
13. Birthplace New York, N. Y.

MOTHER
14. Maiden Name Mary E. Rankin
15. Birthplace Newark, N. J.

16 (a) Informant Mrs. Rosa K. Eichelberger
(b) Address 306 Lexington Ave., New York City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 11 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1944, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1944 to 2/10 1944, and that I last saw h alive on 2/10 1944.

Immediate cause of death Paralysis — Duration 5 da

Due to

Due to

Other Conditions High Blood Pressure & Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: X

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence at M
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Hearn, M. D.
Address 7901 Fairview Ave. Date signed 2/16/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13937
Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 N. Wolfe St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John E. Ehlers (JOHN EDWARD EHLERS)

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/64

8. AGE: Years 79 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arendt Ehlers
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ziegler
15. Birthplace Germany

16 (a) Informant Mrs. Mary M. Ehlers
(b) Address 2009 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1944, at 6 29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 1944, to 2/9 1944, and that I last saw h/m alive on 2/9 1944.

Immediate cause of death Bronchopneumonia. — Duration
Due to Heart failure.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl Myers M.D.
Address Md. Gen. Hosp. Date signed 2/11/44

VS 3

13938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 13938

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Lutherville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Timonium Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Frank Wagoner

3 (b) If veteran, name war --

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1867

8. AGE: Years	Months	Days	If less than one day
76	10	16	hr. min.

9. Birthplace Huntingdon Co., Pa.
(Town, county, and state)
10. Usual Occupation Retired Mechanic
11. Industry or business

FATHER
12. Name Robert Wagoner
13. Birthplace Huntingdon Co., Pa.

MOTHER
14. Maiden Name Catherine Cough
15. Birthplace Huntingdon Co., Pa.

16 (a) Informant Mrs. Anna A. Wagoner
(b) Address Lutherville, Md.

17 (a) Burial (b) Date thereof 2/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 11 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1944 to 2/9 1944, and that I last saw him alive on 2/9 1944.

	Duration
Immediate cause of death Undetermined	
Due to Virus Pneumonia	2 wks.
and Diabetes	1 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles A. Kemp M. D.
Address University Hospital Date signed 2/10

VS 8

13939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1309

G 13939

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raymer Ave & Overland Rd
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

15-10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Berwyn Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J Woods

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1877

8. AGE: Years	Months	Days	If less than one day
66	9	—	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles J Woods
13. Birthplace Pa

MOTHER
14. Maiden Name Lila Rigg
15. Birthplace Montgomery, Md

16 (a) Informant Arthur Woods
(b) Address Pikesville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director John O. Mitchell Sons
(b) Address 400 Eutaw Place

19 (a) FEB 11 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1944, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1944 to Feb 10 1944, and that I last saw h. alive on Feb 9 1944

Immediate cause of death Congestive Heart failure

Due to

Due to

Other Conditions Senile Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm O Mitchell Sons

Address West Baltimore General H. Date signed 2-10-44 M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

3940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G 13940

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lord Baltimore Hotel

(c) Hospital or Institution: none

4-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Lord Baltimore Hotel (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Edward Rennert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Mildred E. Rennert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1862

8. AGE: Years	Months	Days	If less than one day
81	8	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business Hotel Proprietor

FATHER: 12. Name Robert Rennert

13. Birthplace ?

MOTHER: 14. Maiden Name Caroline Brown

15. Birthplace ?

16 (a) Informant Louis J. Burger

(b) Address 86 Maryland Trust Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Edmondson Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

FEB 11 1944 (b) Huntington Williams M.D. Registrar

(Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1943 to Feb 10 1944 and that I last saw h[illegible] alive on Feb 9 1944

Immediate cause of death Asthenocardiosclerosis - My perhaps and dilatation heart failure

Due to Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature F J Tilley M. D.

Address 110 E. North Ave. Date signed 2/14/44

13941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13941
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Harwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Harwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice G. Bull

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George W. Bull
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1867

8. AGE: Years 76 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Harford Co., Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard N. Button
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Mary J. Smith
15. Birthplace New York City

16 (a) Informant Mrs. Maryland Makares
(b) Address 511 Harwood Ave, Balto, Md.

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Jerusalem
Location Sparks, Md.

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

19 (a) FEB 11 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1944, at 9:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1944 to Feb 10 1944, and that I last saw him alive on Feb. 2 1944

Immediate cause of death Pneumonia Bronchial

Duration 0

Due to Acute Cerebral Thrombosis

Duration 4 yrs

Due to

Other Conditions Hypertension

Duration 5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Marr M. D.
Address 716 Park Ave Date signed 2/11/44

E. J. MARR

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AMABile Colantonio

3942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 3942

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Belvedere Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto Highway
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amabile Colantonio

3 (b) If veteran, name war NO

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1880

8. AGE: Years 63 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Italy (town, county and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Ralph Bacciano
13. Birthplace Italy

MOTHER
14. Maiden Name Felomena Campitelli
15. Birthplace Italy

16 (a) Informant John Colantonio
(b) Address 3017 Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Lombard & Amity Sts.

FEB 11 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 2128 W. Saratoga St. Date signed 2/11/44

Attending physician for Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13943

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 83a

G 13943 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4015 Barrington Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 Barrington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Harman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1862

8. AGE: Years 81 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired School Teacher

11. Industry or business Teacher

FATHER 12. Name Jacob Harman,
13. Birthplace Germany

MOTHER 14. Maiden Name Lina Abraham
15. Birthplace Germany

16 (a) Informant Miss R. Wimbey
(b) Address 4015 Barrington Rd

17 (a) Burial (b) Date thereof 2/13/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sonnenheim & Son
(b) Address 902 Eutaw Place

19 (a) (b)
(Date rec'd by Local Registrar) (Signature of Local Registrar)
FEB 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1944, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1944, to Feb 10 1944, and that I last saw her alive on Feb 10 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Arterio-sclerosis cerebral	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Lerman, M. D.
Address 4004 Liberty Hgts Date signed 2/10/44

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G 13944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
Anchorage, [redacted]
(b) Street address [redacted]
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo2ds
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Anchorage, Broadway and Thames
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Sweden

3 (a) FULL NAME JOHN EDWIN TORNBERG

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No.219-12-8069

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife Cora-----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1892

8. AGE: Years	Months	Days	If less than one day
51	7	11	..... hr. ..... min.

9. Birthplace Lund, Sweden
(Town, county, and state)
10. Usual Occupation AB Seaman
11. Industry or business Seafaring

FATHER
12. Name Sudd Tornberg
13. Birthplace Sweden

MOTHER
14. Maiden Name Cleo----------
15. Birthplace Sweden

16 (a) Informant Records---U. S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-44 (month) (day) (year)
(c) Cemetery or crematory St Marys (Hampden)
Location Roland Ave.

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Rd.

19 FEB 11 1944 Lexington Williams M.D.
(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1944 at 6:30a.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1944 to Feb. 9, 1944, and that I last saw him alive on Feb. 9, 1944

Immediate cause of death	Duration
Pulmonary tuberculosis, bilateral, far advanced	Unk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address US Marine Hospital Date signed 2/9/44
Baltimore, Md.

JL G 13945 71540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

✓ G 13945 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -11- 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 S. Ponca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eileen Hendley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1921

8. AGE: Years	Months	Days	If less than one day
22	5 6	16	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Arthur Hendley
13. Birthplace Md.

MOTHER
14. Maiden Name Sophia Omptada
15. Birthplace Md.

16 (a) Informant B. C. H.
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location E-NORTH AVE

18 (a) Funeral director Blanche F. Hoffmann
(b) Address 1639 N Broadway

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

FEB 11 1944

VS-160

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1944, at 4:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1944 to 2-10 1944 and that I last saw h[illegible] alive on 2-10 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Platt M. D.
Address B. C. H. Date signed 2-10-44

G 13946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13946 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 W Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 W Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius McNeil Ray

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 194-07-6223

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Charla Rosa Ray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1894

8. AGE: Years	Months	Days	If less than one day: hr.	min.
49	7	1		

9. Birthplace Miss. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Bethlehem Fairfield

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Sally G.
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Pilgrim Lawn Mem. Park

18 (a) Funeral director Woodruff & Colgan
(b) Address 1400 W Lombard

19 FEB 11 1944 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1944 at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944 to Feb 10 1944 and that I last saw alive on Feb 10 1944.

Immediate cause of death: Lobar Pneumonia — Duration

Due to

Due to

Other Conditions Coronary Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theo. Koldewey M.D.
Address 715 W Pratt Date signed 2/11/44

VS 150

THEO. KOLDEWEY

13947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

G 13947
Registered No.

PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S. Regester Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Eva Parsley (Pietruszka)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mr. Joseph Parsley
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1903

8. AGE: Years 40 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Skrucka
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Ann Pipczynska
15. Birthplace Poland

16 (a) Informant John M. Weber
(b) Address 401 S. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) FEB 11 1944 (Date rec'd by registrar) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1944, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1944, to Feb 10 1944, and that I last saw her alive on Feb 10 1944.

Immediate cause of death
Bronchopneumonia
Pancreatitis
Liver abscess.
Antecedent cause

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: Above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Church Home & Hospital Date signed 2/10/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G 13948

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 13948 Registered No. 52a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Shidmore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife —
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 3 - 1893

8. AGE: Years	Months	Days	If less than one day
50	4 11	7	hr. min.

9. Birthplace Great Barren, N.Y. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace N.Y.

MOTHER
14. Maiden Name Unknown
15. Birthplace N.Y.

16 (a) Informant Mrs. Mary Shidmore
(b) Address Conway St., Ft. Point N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/11/44 (month) (day) (year)
(c) Cemetery or crematory Dist. Patterson Park
Location Bait. State N.Y.

18 (a) Funeral director A. Lee Adel
(b) Address 4 Huntington Ave., Boston, Mass.

19 (a) 1944 (To be filled in by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1944, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed February 11, 1944

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G 13949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓G 13949 Registered No.

169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 Sparrows Pt. Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Morris

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21. 1927

8. AGE: Years	Months	Days	If less than one day
16	8	18	hr. min.

9. Birthplace Sparrows Pt. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Morris
13. Birthplace Greece

MOTHER
14. Maiden Name Elizabeth Mankabis
15. Birthplace Greece

16 (a) Informant James Morris
(b) Address 2608 Sparrows Pt. Rd.

17 (a) Burial (b) Date thereof 2 - 11 - 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore, Md

18 (a) Funeral director Leonard D. Lexington
(b) Address 21 W. 20th St.

19 (a) (Date rec'd by registrar) (b) Hunting for Williams, M.D. (Registrar)

1 VS 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1944, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushing of right thigh

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-8-44 at 9:45 P.M.
(b) Where did injury occur? Marine Engineering Sparrows Pt. - shipyard
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial. While at work? Yes.
(d) Means of injury Struck by train.

23. Signature H. L. Williams M.D.
Medical Examiner.
Date signed 2-9-44

G 13950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 13950 ✓ 61 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Green Sts.
(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 da
(e) Length of stay in Baltimore (yrs., mos., or days) 18 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Caroline
(c) City or town Federalsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lina Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M.

6 (b) Name of husband or wife Samuel Turner
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Mar 6 1890

8. AGE: Years	Months	Days	If less than one day
53	10	5	hr. min.

9. Birthplace Caroline Co Md (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Mat Chase
13. Birthplace Unknown

MOTHER
14. Maiden Name Harriet Morris
15. Birthplace Unknown

16 (a) Informant Samuel Turner
(b) Address Federalsburg Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/14/44 (month) (day) (year)
(c) Cemetery or crematory Federalsburg
Location Federalsburg Md

18 (a) Funeral director J. J. Hampton
(b) Address Federalsburg Md

19 (a) 1 1944 (Date received by registrar) (b) Lynton Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11-1944, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1944, to 2-11 1944, and that I last saw h[illegible] alive on 2-11 1944.

	Duration
Immediate cause of death Unknown	
Due to Diabetes - Gangrene	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-30
Major findings of operations Gangrene Left Foot or Leg
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Patterson M. D.
Address Univ. Hospital Date signed 2-11-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13951 #4758

BALTIMORE CITY HEALTH DEPARTMENT XV G 13951
CERTIFICATE OF DEATH 125B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Shadyside (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location) 5
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Roy Riley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	2		hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Riley
13. Birthplace Virginia

MOTHER
14. Maiden Name Gladys Howell
15. Birthplace Virginia

16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory Quaker
Location Galesville

18 (a) Funeral director T. A. Hardesty & Son
(b) Address Galesville Md.

19 FEB 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1944 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1944 to Feb 11 1944 and that I last saw ~~him~~ alive on Feb. 11 1944.

Immediate cause of death ~~Aspiration~~ ~~of vomitus~~ Atelectasis Duration

Due to Aspiration of vomitus

Due to

Other Conditions Biliary atresia

(Include pregnancy within 3 months of death)

Date of operation 2-10-44

Major findings of operation: Biliary obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rovert Kaye Blake, M.D.
Address Johns Hopkins Hosp. Date signed 2-14-44

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1162

G 13952 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Raleigh (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Reid St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Perrin W. Gower

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Cleo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-14-92

8. AGE: Years 51 | Months 7 | Days 27 | If less than one day: hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Auto. Business

11. Industry or business

FATHER — 12. Name Rom H. Gower
13. Birthplace N.C.

MOTHER — 14. Maiden Name Arrie Hardesty
15. Birthplace N.C.

16 (a) Informant Relative.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/44 (month) (day) (year)
(c) Cemetery or crematory Raleigh, N.C.
Location

18 (a) Funeral director John O. McCullough Undertaking Co.
(b) Address 1900 Eutaw Place

FEB 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944 at 3 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1944 to Feb 11 1944 and that I last saw h[illegible] alive on Feb 11 1944.

Immediate cause of death Shock — Duration 12 hrs

Due to Hemorrhage

Due to Duodenal Ulcer

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb 2, 1944

Major findings of operation Duodenal ulcer

of autopsy Erosion into pancreas

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Branch, M.D.
Address Johns Hopkins Hosp. Date signed 2-11-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 13953

Registered No. 1263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 S. Belnord Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 931 S. Belnord Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances B. Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-18-0194

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9" 13

8. AGE: Years	Months	Days	If less than one day
30	11	1	hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Donaworth
13. Birthplace Poland.

MOTHER
14. Maiden Name unknown
15. Birthplace Poland.

16 (a) Informant George Ruth
(b) Address 739 S. Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14" 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Stanislaus Cem.
Location Dundalk Ave

18 (a) Funeral director Stephen J. Galimore
(b) Address 1800 N. Linwood Ave

19 (a) FEB 1 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1944, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fretam M.D.
Medical Examiner.
Date signed Feb. 10 1944

13954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13954

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Mason Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Burke Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clyde Balzer Edgeworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Anna Marie Edgeworth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26th 1888

8. AGE: Years	Months	Days	If less than one day
55	9	15	hr. min.

9. Birthplace INDIANA
(Town, county, and state)

10. Usual Occupation SUPERVISOR COM. ED'N, CITY

11. Industry or business

FATHER
12. Name Samuel Edgeworth
13. Birthplace Ohio

MOTHER
14. Maiden Name Belle Clybourn
15. Birthplace Indiana

16 (a) Informant Anna Marie Edgeworth
(b) Address 11 Burke Ave - Towson Md

17 (a) Burial (b) Date thereof 2/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

FEB 12 1944 (b) Huntington Williamsport Md
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1944, at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1, 1944 to Feb. 11 1944, and that I last saw h.M. alive on Feb. 11 1944.

Immediate cause of death: Cardiac - Respiratory Failure — Duration: 11 days

Due to: Coronary Thrombosis

Due to:

Other Conditions: Hypertension - Cardio Vascular
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Humphreys Jr M. D.
Address 332 E. University Pkwy Date signed 2/12/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13955 ✓ G 13955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1228 E Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 E Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Leo Allnisi

3 (b) If veteran, name war W

3 (c) Social Security Account No. 215-05-0254

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1892

8. AGE: Years 51 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Sheet Music Store

FATHER
12. Name Robert A Allnisi
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ella M Romaty
15. Birthplace Baltimore Md

16 (a) Informant Mrs Marie F McCarthy
(b) Address 1760 Normandy Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)

(c) Cemetery or crematory Mt Cathedral
Location Baltimore Md

18 (a) Funeral director Wilhelm Sons Inc
(b) Address 1219 St Paul St

19 (a) Date received by registrar FEB 12 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1944 to Feb 11 1944 and that I last saw h[illegible] alive on Feb 11 1944

Immediate cause of death

Cerebral Hemorrhage — Duration a few hours

Due to

Hypertension — Duration 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Green M.D.
Address 1761 E Nor[illegible] Date signed 2/14/44
DeSun

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1043

G 13956
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Catalpha Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rena F. Kisling

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife Jm Kisling
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) Mar 10 1893

8. AGE: Years	Months	Days	If less than one day
50	11	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Durham
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Larrimore
15. Birthplace Md.

16 (a) Informant Lyndel Talley
(b) Address 1329 Patapsco Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A.G. Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Harrington Hollingsworth M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1944 at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1944 to Feb 11 1944 and that I last saw h.er alive on Feb 11 1944

Immediate cause of death	Duration
Thrombosis of Cavernous Sinus	
Due to Cellulitis of face	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
Basilar meningitis
of autopsy Thrombosis Rt. Cavernous Sinus (Specify)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Hagan
Address Greene & Redwood Sts. Date signed 2/14/44

Dr. H. L. Wollenweber MD Asst. Med. Examiner

13957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 6

G 13957 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 9-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Co
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Rockaway Beach (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DEUCHLER DORA ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
N	NONE	F	W	M

6 (b) Name of husband or wife John Deuchler
6 (c) If alive, give age unknown years

7. Birth date of deceased (mo., day, yr.) Oct 11th 1880

8. AGE: Years	Months	Days	If less than one day
63y	3	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation life
11. Industry or business

FATHER
12. Name John Frederick
13. Birthplace Baltimore

MOTHER
14. Maiden Name Knabe
15. Birthplace Germany

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 417 St. Paul St.

19 (a) FEB 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1944 to Feb 10 1944 and that I last saw her alive on Feb 10 1944.

Immediate cause of death: meningitis — Duration: 10 days
Due to: meningococcus
Due to:
Other Conditions: hypertension arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 2-11-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G 13958 ✓ G 13958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3330 Woodland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-18
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3330 Woodland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Gilbert G. Burk

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-09-2200

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Melvin h.

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1879

8. AGE: Years 64 Months 11 Days 4 If less than one day hr. min.

9. Birthplace Baltimore County (Town, county, and state)

10. Usual Occupation Retired insurance Salesman

11. Industry or business Mutual Life Ins Co

FATHER
12. Name Andrew J Burk
13. Birthplace Burk Co. Md

MOTHER
14. Maiden Name Margaret Knight
15. Birthplace Mansfield Co. Md

16 (a) Informant Melvin h. Burk
(b) Address 3330 Woodland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory St James
Location Balto County

18 (a) Funeral director Lauman & Husband
(b) Address 306 Main St Reisterstown Md

19 (a) Date received FEB 12 1944 (b) Registrar Huntington Holliday

V8 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/44 19 at 3:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1943 to 2-10-1944. and that I last saw h Wife alive on 2-9-1944.

Immediate cause of death Carcinoma of intestines — Duration about 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 23-1943

Major findings of operations: Carcinoma of Intestines

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Leland, M. D.

Address 2532 Edmondson Ave Date signed 2-11-44

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

3959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 13959
Registered No.

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Alameda Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Alameda Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm. H. Pensel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widowed

6 (b) Name of husband or wife Kate Clara Yates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1871

8. AGE: Years	Months	Days	If less than one day
72	9	9	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business

FATHER
12. Name Wm. Pensel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Edith P. Graham
(b) Address 2808 Alameda
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof at 12/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Gay St.
18 (a) Funeral director Harry H. Nuthke
(b) Address 401 Edmondson Ave
19 FEB 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1944, at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 44 1939 to Feb 10 1944, and that I last saw h alive on Feb 8 1944.

Immediate cause of death: Acute Cardiac Dil. — Duration: 1 day
Due to: Ch. Valvular Heart Disease
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address 1520 E 33rd Date signed 2/10/44

VS 180

G 13960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. G 13960

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Information is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Druid Hill Ave.
(c) Hospital or institution: Provident Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2716 Fox St (If rural give location)
(e) Citizen of foreign country? Not (Yes or No) If yes, name country

3 (a) FULL NAME Roosevelt Byrd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	married

6 (b) Name of husband or wife Grace Byrd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1907

8. AGE: Years	Months	Days	If less than one day
36	Feb.	7	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business —

FATHER
12. Name Eddie Byrd
13. Birthplace Va.

MOTHER
14. Maiden Name Lucinda Ligon
15. Birthplace Va.

16 (a) Informant Bertha Byrd
(b) Address 44 Convent Ave N.Y. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-44 (month) (day) (year)
(c) Cemetery or crematory Jeterville
Location Va

18 (a) Funeral director Archibald A. Geddis
(b) Address 2101 McCulloh St.

19 (a) FEB 12 1944 (Date rec'd by Reg.) (b) Huntington Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1944, at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31/44 19 to 2/7/1944 and that I last saw him alive on 2/7 1944

Immediate cause of death Post operative Pneumonia — Duration

Due to Complication of Ruptured Gastric Ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-31-44

Major findings of operation: Ruptured Gastric ulcer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Wilson M.D.
Address Provident Hosp. Date signed 2/7/44

G 13961 SAVOY G 13961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 268 Robert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert Savoy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mattie Savoy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 31

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Charles Savoy
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Kennetia Somerville
15. Birthplace Baltimore Md

16 (a) Informant Maggie Savoy
(b) Address 2637 N. Alland St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvert Cemetery
Location Baltimore Md.

18 (a) Funeral director Archibald A. Gaddis
(b) Address 2101 McCulloh St.

19 (a) FEB 12 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1944, at 5:45 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive Cardiovascular disease

Due to: Fracture of right tibia and fibula

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 7 1944 at 9:20 P. M. 1411
(b) Where did injury occur? Intersection of Exeter & Robert Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature H. L. Noelcumber M.D. Medical Examiner
Date signed 2-9-44.
By Howard J. Mesklein, M.D.

3952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G 13962
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W.B.G. Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Bittings No. 1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Dr. John Bittings
13. Birthplace Md

MOTHER 14. Maiden Name Bernardine T. Cuzinski
15. Birthplace Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 11 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) FEB 11 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1944, at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944 to Feb 8 1944, and that I last saw her alive on Feb 8 1944.

Immediate cause of death: Fetal Atelectasis — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. N. Friedman M.D.
Address WBGH Date signed 2/10/44

PLEASE WRITE correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

10723

3963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G 13963
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W.B.M.H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Billings No 2.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph John Billings
13. Birthplace Md

MOTHER
14. Maiden Name Bernadine T. Pazinski
15. Birthplace Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 11 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 11 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1944, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1944 to Feb 8 1944, and that I last saw h Cr alive on Feb 8 1944.

Immediate cause of death: Fetal Atelectasis — Duration: 1 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. N. Friedman M. D.
Address 1501 Eutaw Pl Date signed 2/9/44

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0724

G 13964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G 13964

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3332 Stafford St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3332 Stafford St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Caroline McKitrick Boswell

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick Boswell

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): May 9, 1885

8. AGE: Years 58 | Months 9 | Days 1 | If less than one day: hr. min.

9. Birthplace: Catonsville, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Christopher Leimbach
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Elizabeth Renna
15. Birthplace: Maryland

16 (a) Informant: Frederick Boswell
(b) Address: 3332 Stafford St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12, 1944 (month) (day) (year)
(c) Cemetery or crematory: St. Johns Cem.
Location: Ellicott City, Md.

18 (a) Funeral director: Easton Sykes
(b) Address: Ellicott City, Md

Date received FEB 12 1944 (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1944 at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1942 to Feb 9 1944 and that I last saw h CT alive on Feb 9 1944.

Immediate cause of death: Carcinoma of Liver — Duration: 15 Mo

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. M. Callum M. D.
Address: 3324 Frederick Ave Date signed: 2-11-44

VS 3

3965 G 13965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 W. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July - 7 - 1882

8. AGE: Years	Months	Days	If less than one day
61	7	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Frances P. Martin
13. Birthplace Balto. Md.
14. Maiden Name Mary Ellen Doyle
15. Birthplace Balto. Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 - 12 - 44 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn Cem
Location Richmond Va.

18 (a) Funeral director Miller & Melby Inc
(b) Address 2435 E Oliver St

19 FEB 12 1944 Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1944, at 7 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1944 to Feb. 11 1944 and that I last saw her alive on Feb. 11 1944

Immediate cause of death arteriosclerotic coronary insufficiency — Duration

Due to arteriosclerosis 15 yrs
cholecystitis cholelithiasis 15 yrs
multiple liver abscess

Other Conditions asthma 50 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: all above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M. D.
Address JHH Date signed 2-11

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13966 complete

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13966
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 Southway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Haggett (Maude Estelle Clagett)

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife George D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1871

8. AGE: Years 72 | Months 6 | Days 0 | If less than one day hr. min.

9. Birthplace Cecil Co., Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Winfield Bullock
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Todd
15. Birthplace Md.

16 (a) Informant Mrs. Norman L. Clark
(b) Address 401 Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1944, at 3:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Hers death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to Arteriosclerotic cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Graham M.D.
Medical Examiner.
Date signed February 10, 1944

13967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 13967

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3043 Belmont Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3043 Belmont Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles A. Hutchins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16, 1873

8. AGE: Years	Months	Days	If less than one day
70	3	26 24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business J.J. Haines Co.

FATHER

12. Name William Hutchins

13. Birthplace Baltimore, Maryland

MOTHER

14. Maiden Name Margaret Childs

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Minnie Hutchins

(b) Address 3043 Belmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong

(b) Address 3707 W. North Ave.

19 FEB 12 1944 (Date rec'd by registrar) (b) Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1944, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8, 1944, to Feb. 11, 1944, and that I last saw him alive on Feb. 10, 1944

Immediate cause of death: Coronary Thrombosis — Duration: 3 days

Due to: arteriosclerosis — ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature George A. Kupp M.D.

Address 3030 Edmondson Ave. Date signed 2/11/44

PRACTICE WRITING: Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

13968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13968
Registered No. 6

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RUR and give town)
(d) Street No. 1017 N. Hyde St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Shirley Stephenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Blood | 6 (a) Single, married, widowed, or divorced. Wid

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-83

8. AGE: Years 54 | Months | Days 20 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Woodcock

13. Birthplace Va

MOTHER 14. Maiden Name Jennie

15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs Robert A. Elliott, Dft.
(b) Address 1129 N. Caroline St.

19 (a) FEB 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 19 44 at 12 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 19 44 to 2/9 19 44, and that I last saw h[illegible] alive on 2/9 19 44

Immediate cause of death (Duration)
Cerebral Thrombosis
Due to Meningoencephalitis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rose Kaufman
Address J.H.H. Date signed 2/12/44

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

3969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Please answer each question correctly. Do not leave any blanks. If unknown, write "unknown." If not applicable, write "none." Be sure to give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1757 N. Gay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1757 N. Gay Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest G. Howard

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-22-6010

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sarah Johnson

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 21st, 1883

8. AGE: Years 60 | Months 2 | Days 21 | If less than one day ##### min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business Glen Martins

FATHER
12. Name George M. Howard
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Guy
15. Birthplace Virginia

16 (a) Informant Mrs. Sarah Howard (wife)
(b) Address 1757 N. Gay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14th, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location East End of North Ave. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

FEB 12 1944 Huntington Williams, M.D.
(Date received by registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1944, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1944, to Feb. 11 1944, and that I last saw h/m alive on Feb. 7 1944.

Immediate cause of death: Coronary Thrombosis — Duration: Died

Due to: Arteriosclerotic Cardio-Renal — Duration: 7

Due to: Senile

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene V. Blum, M. D.
Address 1206 E. Preston St Date signed 2/11/44

13970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G 13970
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 days

12-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Pocomoke City (If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARVEY LLOYD BROMLEY

3 (b) If veteran, name war World's War

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edna May French

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) June 10, 1896

8. AGE: Years 47 | Months 8 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Snow Hill, Md. (Town, county, and state)

10. Usual Occupation Farmer- self

11. Industry or business "

FATHER
12. Name John M. Bromley
13. Birthplace Snow Hill, Md.

MOTHER
14. Maiden Name Eva Belle Ellis
15. Birthplace Snow Hill, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)
(c) Cemetery or crematory Methodist Conv.
Location Pocomoke City

18 (a) Funeral director Joshua Bradshaw
(b) Address Snowfield

FEB 12 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH February 11, 1944, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30, 1943 to Feb. 11, 1944 and that I last saw him alive on Feb. 11, 1944.

Immediate cause of death Acute myocardiac infarction — Duration Terminal

Due to

Due to

Other Conditions Cholelithiasis and cholecystitis (Include pregnancy within 3 months of death)

Date of operation 2/12/44 Cholecystectomy

Major findings of operation: Cholelithiasis and cholecystitis

of autopsy: None done

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Cannon M. D.
Address Baltimore, Md. Date signed 2/12/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

Va-14203

G 13971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

148 B

G 13971 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 N. Spring St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Diggs

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 19 1907

8. AGE: Years 34 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Williams

13. Birthplace Md

MOTHER 14. Maiden Name Mary Williams

15. Birthplace Md

16 (a) Informant Walter Carey

(b) Address 422 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director George T. Nelson

(b) Address 1303 Presstman St

FILED (Date received by Registrar) 2 1944 Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1944, at 10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3-1943, to 2-10-1944, and that I last saw h[illegible] alive on 2-8-1944.

Immediate cause of death Carcinoma of Uterus — Duration —

Due to

Due to

Other Conditions General Metastasis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M D Congiss M. D.

Address 611-N. Carey Date signed 2-12-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 13972
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Mengle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary Mueller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years	Months	Days	If less than one day
89			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schlumberger
15. Birthplace Germany

16 (a) Informant Sisters Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 944 Greenmount Ave

19 (a) FEB 12 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 5-9 a.m.

20. DATE OF DEATH Feb. 11 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 - 1944, to Feb-11 1944, and that I last saw him alive on Feb-11 1944.

Immediate cause of death	Duration
Edema of Lungs	1 day.
Due to Chronic Myocarditis	3 yrs
Due to	6 yrs
Other Conditions Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C Gill Hall M. D.
Address 1601 E North Ave Date signed Feb 11-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 288

13973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G 13973 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Kamphaus

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John
13. Birthplace Ge

MOTHER
14. Maiden Name Annie Brunner
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14. 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 944 Frummond Ave

19 FEB 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1944, to Feb 11 1944, and that I last saw [illegible] alive on Feb 10 — 1944.

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Mitral Stenosis	5 yrs
Due to	
Other Conditions Arterio-Sclerosis	8 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed Feb 11-44

G 13974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 13974 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4313 Old York Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth B. Slagsman

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Alonzo Slagsman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15th 1858

8. AGE: Years	Months	Days	If less than one day
86	0	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

FATHER
12. Name Peter Henry Southcomb
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Theodora Lovegrove
15. Birthplace Balto. Md.

16 (a) Informant Edwin L. Slagsman
(b) Address 4313 Old York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)
(c) Cemetery Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Huntington Willis (Registrar) Baltimore, Md.

FEB 2 1944

VS1

for S. W. L. Mollenweber By Howard I. Madeira, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11-44 19 , at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1944 to 2-11 1944 and that I last saw h[illegible] alive on 2-11 1944.

Immediate cause of death Bronchial pulmonary — Duration 6 dys.
Due to Fractured femur.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 27/10
(b) Date of occurrence 12-29-43 at M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At Home (Specify type of place) While at work? No
(e) Means of injury Tripped and fell

23. Signature Charles R. Mollenweber M. D.
Address 1213 Light St Date signed 2-11-44

13975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G 13975

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Warrington Apts
(b) Street address 3908 N. Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Frances Zouck

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Geo P. Zouck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1884

8. AGE: Years 60 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Relay Balto Co
(town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac Hathaway Francis
13. Birthplace Mass.

MOTHER
14. Maiden Name Laura V Simmons
15. Birthplace Balto Co

16 (a) Informant Mr. Wm H Francis
(b) Address Warrington apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 44 (month) (day) (year)

(c) Cemetery or crematory Loudon
Location Balto. Md

18 (a) Funeral director Henry M Jenkins Sons
(b) Address Mc Culloh & Orchard Sts

19 FEB 12 1944 (b) Huntington Williamsport, Md.
(Date received by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1939 to Feb 11 1944, and that I last saw h[illegible] alive on Feb 11 1944.

Immediate cause of death Myocarditis Arteriosclerosis

Duration Several

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Hardy M. D.

Address 1402 Park ave Date signed 2/14/44

I certify that the above is a true and correct statement of the facts relating to the birth, death, or stillbirth of the person named herein, to the best of my knowledge and belief. Physicians: please write the causes of death clearly and legibly. Information regarding parents must be obtained from the most reliable source. Birth date of deceased is especially important.

VS 150

G 13976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 13976 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Homewood Apartments
(c) Hospital or institution: Apt. # 31 2nd St

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Walter Carman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lida Valiant Carman

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 21st 1883

8. AGE: Years 71 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Credit Manager

11. Industry or business Wholesale Merchandise

FATHER
12. Name Bishop Carman
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Catharine Dettrey
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs Charles W Carman
(b) Address Homewood Apartments

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12/44 (month) (day) (year)
(c) Cemetery or crematory St Thomas'
Location Garrison Forest

18 (a) Funeral director Henry H Jenkins' Sons
(b) Address McCulloh & Richard Sts Huntingtn Rd Williams, Md.

19 (a) Date received by Registrar FEB 10 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1944, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28, 1942, to Feb 9, 1944, and that I last saw h[illegible] alive on Feb. 9, 1944.

Immediate cause of death Cardiac failure — Duration 1 yr.

Due to Hypertension & Arteriosclerosis — 20 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Edward Leach M.D.
Address 108 E. 33rd St. Date signed 2/11/44

LEACH

13977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G 13977 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 W. Preston St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 W. Preston St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William Baylor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 66 | Months | Days | If less than one day ___ hr. ___ min.
67

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Coal & wood.

FATHER
12. Name John Baylor
13. Birthplace Virginia

MOTHER
14. Maiden Name unknown
15. Birthplace Virginia

16 (a) Informant William Baylor Jr.
(b) Address 514 W. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory Richmond, Va.
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 965 Druid Hill Ave (b) Huntington Williams, Mgr.

FEB 12 1944 (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10- 1944 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2- 1944 to 2-10- 1944 and that I last saw h in alive on 2-2- 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 wk.
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page
Address 1516 N. Mount St (17) Date signed 2-13-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13978

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 13978 Registered No. 180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Elizabeth Parker

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
—	none	Female	Colored	S

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1889

8. AGE: Years	Months	Days	If less than one day
54	1	16	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Edward Diggs
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rose Wallace
15. Birthplace Md

16 (a) Informant Joseph Diggs
(b) Address 170 Woodyear Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1363 Preastman St

19 (a) FEB 12 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1944, at 5:45 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/1

(a) Date of injury January 24 1944 M.
(b) Where did injury occur? 1517 N. Carey St
(c) Did injury occur at home, on farm, industrial place, in public place? At Home While at work? No
(d) Means of injury Burned in conflagration

23. Signature Robert Lee Frazier M.D. Medical Examiner
Date signed 2-6-11 1944

VS 181

13979
JL - 83407

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53

Registered No. G 13979

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 15 14
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 333 Freestman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Mae Chaney

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1906

8. AGE: Years 37 Months 9 Days 23 If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Wiley Banks
13. Birthplace Ga.

MOTHER
14. Maiden Name Elizabeth Reed
15. Birthplace Ga.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St

19 FEB 12 1944 Huntington Williams M.D. (Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1944, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1943, to 2-8 1944, and that I last saw h alive on 2-8 1944.

Immediate cause of death — Duration

Squamous cell Carcinoma of Perineum and buttocks — 8 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B Kelly M. D.
Address Balto City Hosp Date signed 2-10-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13980
L - 85833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 13B

Registered No. G 13980

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N. Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Elbeck

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1921

8. AGE: Years	Months	Days	If less than one day
22	1	24	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Recapper
11. Industry or business Otole Tire Co.,

FATHER
12. Name Willie Elbeck
13. Birthplace N. C.

MOTHER
14. Maiden Name Beulah Purnell
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Druid Lodge Md

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley Ave.

19 (a) [illegible] (b) Huntington Williams, M.D.

FEB 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9 1944, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1944, to 2-9 1944, and that I last saw h[illegible] alive on 2-9 1944.

Immediate cause of death	Duration
TBC Meningitis	10 days
Due to Pulmonary tuberculosis	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Nettina M. D.
Address B. C. H. Date signed 2/9/44

13981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 13981

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Sharpe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1905

8. AGE: Years 38 Months - Days 1 If less than one day hr. min.

9. Birthplace Ala.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Hattie Norris
(b) Address 301 S. Sharp St.

17 (a) Burial (b) Date thereof 2/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Bryant Lane

19 (a) FEB 12 1944 (b) Waiting for Wife
(Date rec'd by registrar) Medical Examiner, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1944, at 7:45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John T. Wallenmeyer M.D.
Medical Examiner.
Date signed 2-9-44

VS 151

13982

28-86278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G 13982

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 139 N. Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Applewhite

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19-1927

8. AGE: Years	Months	Days	If less than one day
16	7	21 20	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ben Applewhite
13. Birthplace ?

MOTHER
14. Maiden Name Rosie ?
15. Birthplace Ga.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address RECORDS

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)

(c) Cemetery or crematory
Location Wilson, N. C.

18 (a) Funeral director Elwood Wilson
(b) Address 1000 Eighth Ave Huntington Williamson, West Va.

19 FEB 12 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1944 at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1944 to 2/9 1944 and that I last saw her alive on 2/9 1944.

Immediate cause of death: Tuberculous Meningitis. — Duration: 3 wks

Due to Pulmonary Tuberculosis — 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Tuberculous Meningitis Pulmonary T.B.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Acton, M.D. M. D.

Address Balto City Hospitals Date signed 2/10/44

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 13983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G 13983 Registered No. D-13983

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 N. Exeter Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Diggs

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Divorced

6 (b) Name of husband or wife Stanley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1894

8. AGE: Years	Months	Days	If less than one day
49	8	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Powell
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett ?
15. Birthplace Md.

16 (a) Informant Rachel Franklin
(b) Address 1120 Comet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12/44 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest Cem.
Location Towsend Md.

18 (a) Funeral director Mrs. Robert A. Elliott Sr.
(b) Address 1297 N. Carlton St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 3-

20. DATE OF DEATH Feb. 8, 19 44 at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/3/ 19 44 to 2/8 19 44 and that I last saw h.. alive on 2/3/ 19 44

Immediate cause of death	Duration
Intestinal obstruction	1/30 M
Due to Carcinoma (Gall Bladder)	?
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis B Lutz M. D.
Address 7501 E. Eager St Date signed 2/13/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly

VS 180

G 12984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

G 13984 Registered No.

1. PLACE OF DEATH:
(a). Baltimore City, Maryland
(b) Street address 3009 Ailsa Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Ailsa Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Herman Schmidt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1926

8. AGE: Years	Months	Days	If less than one day: hr.	min.
17	4			

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation school
11. Industry or business

MOTHER / FATHER
12. Name John Schmidt
13. Birthplace Baltimore
14. Maiden Name Nanny Schmidt
15. Birthplace Baltimore

16 (a) Informant Mr. John Schmidt
(b) Address 3009 Ailsa Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ /44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore - Md.

18 (a) Funeral director Bernard J. Ruck
(b) Address 530 Harford Road

FEB 13 1944 (Date received by registrar) (b) Wilson for Walter [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1944 at 7.47 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1943 to Feb 11 1944 and that I last saw h[illegible] alive on Feb 10 1944.

Immediate cause of death Subacute Bacterial Endocarditis.
Due to Rheumatic Heart Disease.
Due to Congenital Heart Disease.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
6 mo
[illegible]
life

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Sawyer, M.D.
Address 4808 Harford Rd. Date signed 2/11/44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G 12985

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3011 Alma Avenue (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry K Addison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mabel E Knafle

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug. 20-1869

8. AGE: Years	Months	Days	If less than one day
74	5	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Joseph S. Addison
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Mabel E. Addison
(b) Address 3011 Alma Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5805 Harford Rd.

FEB 13 1944 (Date rec'd by registrar)

(b) Huntington Hollins M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1944 at 5 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1944 to 2-12 1944.
and that I last saw him alive on 2-11 1944.

Immediate cause of death	Duration
(a) Uremia	
Due to (b) Urinary retention	
Due to (c) Prostatic hypertrophy	
Other Conditions Decompensated heart. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph's Hospital Date signed 2-12-44

VS 150

C 13986

BALTIMORE CITY HEALTH DEPARTMENT ✓ X C 13986 Registered No.

CERTIFICATE OF DEATH 46B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale & Greene
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town Waldorf (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Reed

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name unknown
13. Birthplace "

MOTHER 14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Hosp. Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/44 (month) (day) (year)
(c) Cemetery or crematory
Location Waldorf, Md

18 (a) Funeral director Hunt & Ryon
(b) Address Waldorf, Md.

FEB 15 1944
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 19 44, to Feb 10 19 44, and that I last saw him alive on Feb 10 19 44.

Immediate cause of death	Duration
carcinomatosis	
Due to Carcinoma of Stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. N. Carpenter M. D.
Address Univ. Hosp Date signed 2/16/44

VS 8

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

44983 213987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 13987 Registered No. 14

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland .
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Emmittsburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 336 Seaton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Johnson

3 (b) If veteran, name war World War #1

3 (c) Social Security Account No. 216-18-2492

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 7-15-95

8. AGE: Years 48 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Page Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Celonia Parker
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. View Cemetery
Location Emmitsburg, Md

18 (a) Funeral director S. L. Allison
(b) Address Emmitsburg, Md

(c) Date received FEB 13 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944, at 10 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944, to Feb 11 1944, and that I last saw him alive on Feb 11 1944.

Immediate cause of death: Meningitis (? tuberculosis) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Burningham JHH M. D.
Address Date signed 2-12

G 13988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 13993

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2010 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick B. Pyle

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Virginia S. Pyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 16 December 1867

8. AGE: Years	Months	Days	If less than one day
76	1	26	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Retired Conductor
11. Industry or business Balto. T. Co.

FATHER
12. Name Amos Pyle
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Rebecca Ward
15. Birthplace Harford Co. Md.

16 (a) Informant Virginia S. Pyle
(b) Address 2010 W. Fayette St.

17 (a) Burial (b) Date thereof Feb. 13-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Chapel
Location Harford Co. Md.

18 (a) Funeral director George L. Schmidt
(b) Address 2101 Fulton ave.

19 (a) FEB 13 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 February 1944 at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1944 to Feb. 11 1944, and that I last saw h[illegible]live on Feb. 11 1944.

Immediate cause of death	Duration
Uremia	6 days.
Due to Cardio vascular renal disease	4 years
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin Pharamond M.D.
Address 1904 W. Balto St. Date signed 2-12-44

VS 3

PASSING

G 13989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G 13989

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Towanda (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Yarmor

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-0063

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Anna R Yarmor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1880

8. AGE: Years	Months	Days	If less than one day
63 64	6		hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name Jacob Yarmor
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Hosp. Record
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 12/44 (month) (day) (year)

(c) Cemetery or crematory
Location Atlantic City N.J.

18 (a) Funeral director A. Pesley Slade
(b) Address 4902 York Road

FEB 13 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1944 at 11 40 M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Charles F. Lubinski M.D. Medical Examiner.
Date signed 2/12/44

Charles F. LUBINSKI

VS 151

C 13990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 469 C 13990

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Johnstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Hrbek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Dwight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-93

8. AGE: Years	Months	Days	If less than one day
50	3	18	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew Jackson
13. Birthplace Pa

MOTHER
14. Maiden Name Sue Potts
15. Birthplace Pa.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-44 (month) (day) (year)
(c) Cemetery or crematory
Location Johnstown Pa.

18 (a) Funeral director G. Lee Ecker
(b) Address 4644 York Rd

19 (a) FEB 13 1944 (Date received by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 12 1944
and that I last saw her alive on Feb 12 1944

Immediate cause of death
Hypostatic pneumonia
Due to Tumor mass U.U.D.
Enlarged Spleen
Due to Pleural effusion, cause

Other Conditions Related Paroteles

Duration 4 mo.

(Include pregnancy within 3 months of death)
Date of operation 1-12-44 Pathology Laboratory
Major findings of operation:
Tumor body & cauda, ? metastasis
of autopsy: Splenomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Mood, Jr. M. D.
Address Johns Hopkins Hosp Date signed 2-17-44

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G 13991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57D

G 13991 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2031 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D 2 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Hamilton Crawford

3 (b) If veteran, name war	3 (c) Social Security Account No. 705-10-2394

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret E. Crawford
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) August 22, 1882

8. AGE: Years	Months	Days	If less than one day
61	5	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Incapacitated Carmen
11. Industry or business B & O RR

FATHER
12. Name James Franklin Crawford
13. Birthplace Montgomery County, Md.

MOTHER
14. Maiden Name Ida May Airey
15. Birthplace Church Creek, Md.

16 (a) Informant Mrs. Margaret E. Crawford
(b) Address 2031 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lamonor
(b) Address 1803 W. Baltimore St.

19 (a) (Signature of Registrar) Huntington Williams, M.D.
(Date received by Registrar) FEB 15 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1944, at 4.05A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to Feb 11 1944 and that I last saw him alive on 2/10 19 44

Immediate cause of death	Duration
Hemorrhage from internal coat	½ hr.
Due to Erosion of cerebral art and	8 mo.
Due to Brain Tumor	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. C. Wells M. D.
Address 4100 Edmondson Ave. Date signed

The correct age is especially important. Physicians; please write the causes of death clearly and legibly. Information should be carefully supplied. The

13992

HEALTH DEPARTMENT—CITY OF BALTIMORE

13992

CERTIFICATE OF DEATH

✓ X 83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Nursing Home St. 19 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Harry Burke

If U. S. Veteran specify WAR

(a) Residence: No. 250 S Liberty Pkwy Ward. Dundalk Baltimore Co.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Helen M.

6. DATE OF BIRTH (month, day, year) 8/30/1880

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63 67	5	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Carpenter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME J. H. Burke

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Elizabeth Liddel

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Helen M. Burke (wife)
(Address) 250 S Liberty Pkwy

18. BURIAL, CREMATION, OR REMOVAL
Place Oak Lawn Date Feb 16 19 44

19. UNDERTAKER Ulman Funeral Home
(Address) 1001 Orleans St

Filed FEB 13 1944 Howard Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 11, 1944

22. I HEREBY CERTIFY, That I attended deceased from May 30, 1940 to Feb 11, 1944

I last saw him alive on Feb 11, 1944. Death is said to have occurred on the date stated above, at 5:45 P. m.

The principal cause of death and related causes of importance were as follows:

Paralysis — Date of onset 3 Yrs

Other contributory causes of importance:

Cerebral Haemorrhage — Date of onset 1 Day

Was an operation performed? No. Date of

For what disease or injury?

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) L. A. Thanhauser M. D.

(Address) 112 W. 20 St

(Over)

OCCUPATION is very important. See instructions on back of certificate.

G 13993 Melvine Kempel G 13993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH Registered No. 1246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Clarkson Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Melvine Kempel

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-4420

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles W. Sr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17-1891

8. AGE: Years 52 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Houseworker

11. Industry or business at home

FATHER
12. Name George W. Behrens
13. Birthplace Baltimore md

MOTHER
14. Maiden Name Philipina E. Bowers
15. Birthplace Baltimore Md

16 (a) Informant Chas W. Kempel Jr
(b) Address 1509 Clarkson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director Wm F. Porter
(b) Address 2836 W. North ave

19 (a) (Date rec'd by registrar) (b) Registrar
FEB 15 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10-44 19 , at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 19 43 to 2-10 19 44
and that I last saw her alive on 2-10 19 44

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Portal Cirrhosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-21-44

Major findings of operation Exploratory Portal cirrhosis

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St Date signed 2-10-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 13994 Registered No. 472

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3011 WYLIE AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 43 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 WYLIE AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SAMUEL KLITZNER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife EVA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER
12. Name SIMON
13. Birthplace RUSSIA

MOTHER
14. Maiden Name SARAH
15. Birthplace RUSSIA

16 (a) Informant EVA KLITZNER
(b) Address 3011 WYLIE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-13-44 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Park Rd + HAMILTON AVE

18 (a) Funeral director Jack Louis Inc.
(b) Address 1439 E. Baltimore ST

19 (a) (Date received by registrar) (b) [illegible] Registrar

B 13994 WS 100

MEDICAL CERTIFICATION 35

20. DATE OF DEATH 2-11-44 19.. at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 43 to 2/11 1944, and that I last saw [illegible] alive on 2/11/44.

Immediate cause of death Carcinoma of bladder — Duration 1 yr

Due to:

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 2904 Rusted Date signed M. D. 2/13/44

G 13995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G 13995 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere + Greenspring Ave
(c) Hospital or institution:
Hebrew Home for Aged + Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere + Greenspring (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elsa Moses

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Bernhard Moses
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Steinberg
15. Birthplace Germany

16 (a) Informant Felix Rosenbach
(b) Address 2239 Brookfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) (Official capacity of registrar) (b) [illegible] (Registrar)

FEB 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1944 at 1.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1943 to Febr. 10 1944, and that I last saw her alive on Febr. 10 1944.

Immediate cause of death: Carcinoma of stomach — Duration: 5 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Klein
Address Lorndale Date signed 2/15/44

Vs 130

G 13996

G 13996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Calvert St.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore - 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1239 N. Broadway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/16/38

8. AGE: Years	Months	Days	If less than one day
5	6	1	27 — hr. — min.

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business —

FATHER
12. Name Dale Davis
13. Birthplace West Virginia

MOTHER
14. Maiden Name Leona Beverly
15. Birthplace West Virginia

16 (a) Informant Mrs. Dale Davis
(b) Address

17 (a) Removal (b) Date thereof 2-13-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Salem W Va

18 (a) Funeral director George A. Farley
(b) Address Fulton & Fayetteville

2 13 1944
(Date rec'd by registrar)

(Huntington) Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12/44 1944 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1944 to 2/12 1944 and that I last saw her alive on 2/12 1944.

Immediate cause of death
Congestive Heart Failure — Duration 4 days
Due to Rheumatic Heart Disease — 26 days
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. B. McCracken M. D.
Address Mercy Hospital Date signed

G 13997

G 13997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 244 S Monastery
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 244 S Monastery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M J Fusby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Stephen P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20 1857

8. AGE: Years 86 | Months 5 6 | Days 16 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Eli Lusby
13. Birthplace Maryland

MOTHER 14. Maiden Name Not Available
15. Birthplace " "

16 (a) Informant Mrs Morgan S Matthews
(b) Address 244 S Monastery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)

(c) Cemetery or crematory Edmondson
Location Edmondson Town Md

18 (a) Funeral director George A Epley
(b) Address Fulton Ave & Fayette

19 (a) FEB 2 1944 (Date received by registrar) (b) Lucy Lee Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1943 to 2/11 1944
and that I last saw her alive on 2/10 1944.

Immediate cause of death Coronary Thrombosis — Duration 12 Days

Due to Cardio Vascular Disease — 1 Year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot W Johnson M. D.
Address 2432 Druid Hill Ave Date signed

VR 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13998

G 13998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME CLARA MANNS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
64			..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Leonidas Folemon
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mary Rose F. J. Manns
(b) Address 468 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director George H. Farley
(b) Address Fanlon & Paquette

19 (a) ..... (b) ..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1944, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an enquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Lung
Bronchogenic
Due to .....
.....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed 2-16-44

VS 151

G 13999 G 13999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 E. Preston St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Victor F. Lochte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary T. Schaub
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 26, 1883

8. AGE: Years	Months	Days	If less than one day
60	10 3	26 16	-- hr. --- min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business ------

FATHER
12. Name Frank Lochte
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Coffey
15. Birthplace Ireland

16 (a) Informant Mrs. Victor F. Lochte
(b) Address 418 E. Preston Street

17 (a) Burial (b) Date thereof 2/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert Street

19 (a) _____ (b) _____
(Date rec'd by registrar) Registrar

FEB 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944 at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Feb 11 1944 and that I last saw him alive on Feb 9 1944.

Immediate cause of death Cerebral hemorrhage — Duration 4 hrs.

Due to Arterial hypertension & arteriosclerosis.

Due to _____

Other Conditions Left hemiplegia 3 Yrs.

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)
(e) Means of injury _____

23. Signature William R. Straight M.D.
Address 10 E. Biddle St. Date signed 2/13/44

COPIES for the use of physicians, undertakers, registrars, and others concerned in the registration of deaths and burials.

G 14000

BALTIMORE CITY HEALTH DEPARTMENT X G 14000
CERTIFICATE OF DEATH 122a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Catonsville Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 41 Beamsburyave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Martin A. Kenealy

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War - I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Cora M. Kenealy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - 2 - 1875

8. AGE: Years	Months	Days	If less than one day
68	10	8	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER 12. Name Martin Kenealy
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Mulvey
15. Birthplace Ireland

16 (a) Informant Cora M. Kenealy
(b) Address 325 Yale Ave Lafayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Baltimore - Md.

18 (a) Funeral director Peter S. MacNabb
(b) Address Redwood & Wolfe Ave

19 (a) FEB 12 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 10 1944 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 7 1944, to 2 - 10 1944, and that I last saw h[illegible] alive on 2 - 7 1944.

Immediate cause of death	Duration
Congestive Heart Failure	2 days
Due to Hypertensive Cardio - Vas. Disease	
Due to	
Other Conditions R.O. Ventral Hernia.	

(Include pregnancy within 3 months of death)

Date of operation 2 - 8 - 44
Major findings of operation: Post. M. Ventral Hernia.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel Jr. M. D.
Address Bon Secours Hosp. Date signed 2-10-44

G 14001 4 1944 BALTIMORE CITY HEALTH DEPARTMENT G 14001 Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH: Franklin Sq. Hosp.
(a) Baltimore City, Maryland
(b) Street address Fremont & Carlton Sts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 N. Morley St. (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME George H. Geldmacher

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-09-3535

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Louise W.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 4th 1880

8. AGE: Years 63 Months 6 Days 6 If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business Atlantic Fur. Prod. Co.

FATHER
12. Name Henry Geldmacher
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Emma Smith
15. Birthplace Baltimore Md.

16 (a) Informant Louise W. Geldmacher (Wife)
(b) Address 35 N. Morley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery ~~Forest~~ Louden Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director Frank Dellahoe
(b) Address 52 N. Morley St.

19 (a) ..... (Date rec'd by registrar) Huntington Williams M.D. Registrar

FEB 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1944, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10, 1944, to Feb. 19 1944, and that I last saw h. alive on ..... 19 ..... .

Immediate cause of death: Coronary Sclerosis — Duration

Due to Fatty Edema

Due to Exhaustion

Other Conditions Dead on arrival to Hospital
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. E. Fowler M.D.

Address ..... Date signed 2/16/44

G 14002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14002 Registered No.

TL- 86236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 1041 N. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Mary Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1889

8. AGE: Years 54 | Months 5 6 | Days 2 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Leven Joyner
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Seebough
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/13/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto Co., Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) 1644 N. Montgomery St

19 (a) (b) (Date rec'd by registrar) Registrar

VS-180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9 1944, at 5 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1944, to 2-9 1944, and that I last saw h[er] alive on 2-9 1944.

Immediate cause of death: Bronchopneumonia
Carcinoma Thumb
Due to Senile Arteriosclerosis

Due to Arteriosclerotic Gangrene Lt Foot

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-5-44

Major findings of operation: Lt Foot Gangrene

of autopsy: Above

Duration
day
7
9

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B. Kelly M. D.
Address Balto City Hosp Date signed 2-10-44

Huntington Williams, M.D.

G 14003 ✓ G 14003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 48B

1. PLACE OF DEATH — Registered No. .....

CITY OF BALTIMORE: (No. 5321 Denmore Ave St., 8 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Carrie Brown

(a) Residence: No. 5321 Denmore St., Ward. .....
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	colored	

6a. If married, widowed, or divorced: HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) 1857

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
87 yrs 1857	—	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. cook

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) Jan '44

11. Total time (years) spent in this occupation 60 yrs

12. BIRTHPLACE (city or town) (State or country) Balto Co

FATHER

13. NAME Elijah Quickley

14. BIRTHPLACE (city or town) (State or country) Balto Co

MOTHER

15. MAIDEN NAME Annie Quickley

16. BIRTHPLACE (city or town) (State or country) Balto Co

17. INFORMANT Carrie Pettus
(Address) 5321 Denmore Ave

18. BURIAL, CREMATION, OR REMOVAL Burial
Place Mt Bravo Date Feb 13, 1944

19. UNDERTAKER Thos. Geo. Holland
(Address) 1631 Bond St

20. Filed Feb 13, 1944 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 8, 1944

22. I HEREBY CERTIFY, That I attended deceased from Jan 9th, 1944 to Feb 8, 1944

I last saw her alive on Jan 7th 1944 Death is said to have occurred on the date stated above, at 7 A.M.

The principal cause of death and related causes of importance were as follows:

	Duration
Cancer of the Uterus	8 mo 1443
Other contributory causes of importance: Fibroid Tumor of Uterus	seven years

Name of operation none Date of ...

What test confirmed diagnosis? Nasal Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? No Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) D Grant Pettus, M. D.

(Address) 354 N. Biddle St

G 14004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G 14004 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3567 Buena Vista Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE REDMOND AMOS

3 (b) If veteran, name war	3 (c) Social Security Account No.
World's War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1892

8. AGE: Years	Months	Days	If less than one day
52	0	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer - 12/43
11. Industry or business ?

FATHER
12. Name John Thomas Amos
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Kate V. Wilhelm
15. Birthplace Balto. Co., Md.

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Maryland Balto Co Md

18 (a) Funeral director Wilhelm Undertaking Co
(b) Address 1217 E. Fort Ave

19. (a) Filed FEB 14 1944 (b) Registrar
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Feb. 11, 1944 at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9, 1944 to Feb. 11, 1944 and that I last saw h. im alive on Feb. 11, 1944.

Immediate cause of death	Duration
Arteriosclerotic heart disease with congestion	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None done
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature J. C. Archer M. D.
Address Baltimore, Md. Date signed 2/12/44

Va-14293

G 14005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55 E Registered No. G 14005

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison st
(c) Hospital or institution: Crawford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2452 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Emma Powell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1864

8. AGE: Years	Months	Days	If less than one day hr.	min.
79	3	28		

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER | FATHER

12. Name Stephen Powell

13. Birthplace Balto. Md.

14. Maiden Name Ida Inlaws

15. Birthplace Balto. Md.

16 (a) Informant Mrs Luke Raley

(b) Address 2452 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16-44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st

19 (a) (b) Hunterstown Pa.

(Date received by Registrar) FEB 14 1944

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13th 1944, at 3 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1943 to 2/13 1944 and that I last saw h[illegible] alive on 2/12 1944

Immediate cause of death Acute Peripheral Vascular Failure — Duration 2 hours

Due to Chronic Hemorrhage — 1 yr

Due to Lymphosarcoma (Cervical) — 8 yrs (a)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Tyler E. Powell M. D.

Address 3629 Edmondson Ave Date signed 2/13/44

Correct age is especially important. Physicians: please answer the questions on death cards and return promptly.

14006
JL - 86168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 14006
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Finn

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16, 1890

8. AGE: Years	Months	Days	If less than one day
53	9 19	25	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Finn
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann McQuillan
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB. 14 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location 46 Frederick Road

18 (a) Funeral dir. Chas. J. Evans, Son
(b) Address 418 N. McCulloh Ave

19 (a) FEB 14 1944 (Date rec'd by registrar) (b) Hunter H. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11 1944. at 6.40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1944. to 2-11 1944.
and that I last saw h.r alive on 2-11 1944.

Immediate cause of death	Duration
Uremia	?
Duetto Progress of lower left hemiplegia	1 mo.
Due to Cardiorenal disease of Arteriosclerotic type	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Mathews M.D.
Address B.C.H. Date signed 2/11/44

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 123

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8yrs-10mos-23days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 St. Ambrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Murray Yingling

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Cora Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21-1881

8. AGE: Years	Months	Days	If less than one day
62	7 6	23 22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Howard T. Yingling
13. Birthplace Md.

MOTHER
14. Maiden Name Bell Maize
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS RECORDS
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT
Location GREENMOUNT AV. OLIVER ST
18 (a) Funeral director CHAS. F. EVANS & SON
(b) Address 118 W. MT. ROYAL AVE
19 (a) FEB 14 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1944, at 9 20 M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1944, to Feb 13 1944, and that I last saw him alive on Feb. 13 1944.

Immediate cause of death Uremia — Duration 1 wk.
S.I hemorrhages

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation? —

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Earl R. Kinney M. D.
Address Balt. City Hospitals Date signed 2/13/44

14008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

✓ G 14008 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Marie Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1881

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	7	24		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Labour
11. Industry or business Carr-Fowzer Co.

FATHER
12. Name Frederick Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Boerna
15. Birthplace Germany

16 (a) Informant Miss Edna Conrad
(b) Address 2037 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director E. J. Tamburro (Jr)
(b) Address 1938 E. Lafayette ave

19 (a) 2 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 10 1944 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 7 1944 to 2 - 10 1944 and that I last saw h i ~~m~~ alive on 2 - 10 1944

Immediate cause of death Peritonitis — Duration 2 Wks.

Due to Intestinal Obstruction

Due to Carcinoma of rectum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of rectum.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hayley B. Klyanowicz
Address St Josephs Hosp Date signed 2-12-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14009
Registered No.

17a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Truxtun
(c) Hospital or institution:
Community
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) same

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Toronis
(c) City or town Guantico
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hall.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3-1923

8. AGE: Years	Months	Days	If less than one day
21	1	9	hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Benjamin Hall
13. Birthplace md

MOTHER
14. Maiden Name Zoha Bailey
15. Birthplace Md

16 (a) Informant Benjamin Hall
(b) Address Whitehaven Md

17 (a) Burial (b) Date thereof 2-14-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stephens Field
Location Whitehaven Md
18 (a) Funeral director Jno. H. Chase & Son
(b) Address 63 E. N. Gilmor

FEB 14 1944
(Date received by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1944, at 4 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 23 1943 to Feb. 12 1944, and that I last saw h[illegible] alive on Feb. 12 1944.

Immediate cause of death Section of cervical cord

Due to Collapse of cervical vertebrae

Due to Tuberculous Osteomyelitis

Other Conditions Generalized bone & pulmonary tuberculosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Tbc meningitis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Palmer M. D.
Address Community Hospital Date signed 2/15/44

G 14010 FONSECA ✓ 107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14010 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 madisonave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore ✓ (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Margaret Fonseca ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4, 1944

8. AGE: Years	Months	Days	If less than one day
	1	7	hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Mcquikle Fonseca
13. Birthplace md

MOTHER 14. Maiden Name Elsie Frazier
15. Birthplace md

16 (a) Informant Elsie Fonseca
(b) Address 1510 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Geo L. Kelso
(b) Address 1303 Eutaw St

FEB 14 1944 (Date rec'd by registrar)

(a) (b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular
Primary -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Wollenweber M.D. Medical Examiner.
Date signed February 12, 1944

VS 151

G 14011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G 14011

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Lorman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Brooks

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3, 1935

8. AGE: Years	Months	Days	If less than one day hr.	min.
8	6	8		

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name London Brooks
13. Birthplace Md.

MOTHER
14. Maiden Name Jennie Knotts
15. Birthplace Md

16 (a) Informant London Brooks
(b) Address 1825 Lorman st

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore City

18 (a) Funeral director Geo G. Robson
(b) Address 1803 Presstman St

FEB 14 1944 (b) Huntington Ave Baltimore
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 11 1944, and that I last saw her alive on Feb 11 1944.

Immediate cause of death Rheumatic Heart Disease — Duration
Due to Mitral Insufficiency + Stenosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hosp Date signed 2/4/44

C 14012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C 14012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 W. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Stevenson

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Eulalia
6 (c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) Mar. 9, 1895
8. AGE: Years 48 | Months 11 | Days 2 | If less than one day: hr. min.
9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Retired Postal Clerk
11. Industry or business

FATHER
12. Name John D. Stevenson
13. Birthplace Va

MOTHER
14. Maiden Name Rebecca Johnson
15. Birthplace Md.

16 (a) Informant Eulalia Stevenson
(b) Address 1719 W. Lafayette Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.
18 (a) Funeral director Joseph G. Cook, Jr.
(b) Address 1304 N. Central Ave
19 (a) FEB 14 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1944 at 1 30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Feb 11 1944, and that I last saw him alive on Feb 10 1944.

Immediate cause of death: Coronary Occlusion — Duration 1 day
Due to: Cerebral
Due to:
Other Conditions: Hernia Inguinalis sinistra
Nephritis and Hypertension
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: None
of autopsy: None

Complete items

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ralph E. Young, M.D.
Address 1429 E. Monument St. Date signed 2/12/44

G 14013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 14013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1319~~ 1318 N. Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Sachs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1872

8. AGE: Years 71 | Months 4 | Days 14 13 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Karl Sachs
13. Birthplace

MOTHER
14. Maiden Name Wilhemina Sachs
15. Birthplace

16 (a) Informant Mr. King
(b) Address 327 St. Paul Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location O'Donnell St.

18 (a) Funeral director Howard M. Blight Jr.
(b) Address 4914 Belair Road

19 (a) (Date received by Local Registrar) (b) Huntington Williams M.D. Registrar

FEB 11 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1944, at 8.00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed February 11, 1944

14014

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

G 14014

Reg. Dist. No.

CERTIFICATE OF DEATH

50

1. PLACE OF DEATH:
(a) County
(b) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 4918 Leondelia Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 40 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 4918 Leondelia Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

(a) FULL NAME Adella R. Justice

(b) If veteran, name war

3 (c) Social Security No.

Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

(b) Name of husband or wife John Stephen Justice

6. (c) If alive, give age 75 years

Birth date of deceased (mo., day, yr.) May 2/1871

AGE: Years 72 Months 9 Days 10 If less than one day hr. min

Birthplace Maryland
(Town, county, and state)

Usual occupation

Industry or business At home

12. Name Daniel Kieffer

13. Birthplace Penna

14. Maiden Name Elizabeth Hoover

15. Birthplace Penna

(a) Informant John Stephen Justice

(b) Address 4918 Leondelia Ave

(a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 14 1944 (month) (day) (year)

(c) Cemetery or crematory Sater

Location Brooklandville Md.

(a) Funeral director Harry H. Armacost

(b) Address 4204 Ridgewood Ave

FEB 11 1944 (Date rec'd by registrar)

(b) Huntington Hills

MEDICAL CERTIFICATION

20. Date of death 2-12 1944, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-38 to 2-12-1944 and that I last saw him alive on 2-11-44

Immediate cause of death Pneumonia

Duration 2 yrs.

Due to

Due to

Other conditions Cachexia

(Include pregnancy within 3 months of death)

Major findings

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jessie G. Saffell (M.D. or other)

Address Reisterstown Md Date signed 2-12-44

14015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. G 14015

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4330 Willow Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4330 Willow Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerry Goodeen (Goodman)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife Josephine Goodeen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1865

8. AGE: Years	Months	Days	If less than one day: hr.	min.
78	77	10	3	

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jerry Goodeen
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Josephine Matthews
(b) Address 4330 Willow Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location D. A. Co. Md.

18 (a) Funeral director Belmont Mamie McKnight
(b) Address 721 Chaquette St

FEB 14 1944 Huntington Williams M.D.
Date received by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1944 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1944 to Feb. 10 1944, and that I last saw h alive on Feb. 10 1944

Immediate cause of death Cerebral Hemorrhage — Duration 2 Days
Due to La Grippe — ?
Due to Uremia — 4 days

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 420 E. Chase Date signed Feb. 11. 44

Please write plainly, with pen or pencil; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14016

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1436 William St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Same.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob J. Buttner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Carrie E. Seipp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29, 1879

8. AGE: Years	Months	Days	If less than one day
64	7	12	hr. min.

9. Birthplace Same. (Town, county, and state)
10. Usual Occupation Ret. Foreman
11. Industry or business Sinclair Co.

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family.
(b) Address 1436 William St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Ave.
18 (a) Funeral director Geo. L. Lemley
(b) Address 120 E. Lexington St.

FEB 14 1944 (Date rec'd by registrar)
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1944 at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to Feb 11 1944.
and that I last saw him alive on Feb 11 1944.

Immediate cause of death Cerebral Hemmorhage
Duration 4 days
Due to Nephritis
Due to Arteriosclerosis
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Kuhnes M.D.
Address 263 E. Monument St Date signed 2/13/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 14017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. WYMAN PARK APTS. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JACKSON BRANDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/1865

8. AGE: Years	Months	Days	If less than one day
78	5	8	hr. min.

9. Birthplace ENGLAND (Town, county, and state)

10. Usual Occupation STOCK BROKER

11. Industry or business

FATHER
12. Name WILLIAM BRANDT
13. Birthplace ENGLAND

MOTHER
14. Maiden Name ANNIE KUNKLE
15. Birthplace ENGLAND

16 (a) Informant MRS. ROBERT AXTELL
(b) Address 2540 Clermont Ave; Kenilworth

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 44 (month) (day) (year)

(c) Cemetery or crematory London Park
Location 3804 Frederick Ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1600 Eutaw Place

19 (a) FEB 14 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 11 1944 at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 28 1944, to Feb. 11 1944, and that I last saw h.i.M. alive on Feb 10 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Coronary Thrombosis — Duration

Due to Lobar Pneumonia — Duration 14 days

Other Conditions Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia Arteriosclerotic Heart Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Dell III M. D.
Address Union Memorial Hosp Date signed 2-11-44

G 14018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G 14018 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5700 Sefton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 5700 Sefton Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET VIRGINIA HARDEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Wm. E. Harden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 29, 1866

8. AGE: Years	Months	Days	If less than one day
77	10	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Thomas Gettier
13. Birthplace Md.

MOTHER
14. Maiden Name Sara Ann Briggs
15. Birthplace Md.

16 (a) Informant Mrs. Ethel Gettier Lohrfink
(b) Address 504 Hollen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 14 1944 (Registrar) (b) Thursday [illegible] Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1944, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to 2/12 1944 and that I last saw her alive on 2/12 1944.

Immediate cause of death Hypertension Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 5703 Harford Rd. Date signed 2/14/44

G 14019 Incomplete!

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 14019

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HARMAN RITTERHOFF

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1868

8. AGE: Years	Months	Days	If less than one day
75	4		hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Retired Candy Mfg.

11. Industry or business

FATHER 12. Name Frederick Ritterhoff

13. Birthplace Germany

MOTHER 14. Maiden Name Mary W. Harms

15. Birthplace Md.

16 (a) Informant Mr. Charles J. Ritterhoff (cousin)
(b) Address 3510 Denison Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

FEB 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1944, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Feb. 10 1944.
and that I last saw alive on Feb. 10 1944.

Immediate cause of death Coronary Thrombosis — Duration ½ day

Due to Coronary Sclerosis — Duration 4 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. S. Jones M. D.

Address 516 Dallas St. Date signed Feb 14 44

G

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Certificates of death should be carefully supplied. The

G 14020 ✓ G 14020

#49190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Demarcay Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry C. Wiland
3 (b) If veteran, name war None
3 (c) Social Security Account No. 220-07-6142

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Beulah Wiland
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Sept 6 - 1902

8. AGE: Years 41 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Welder
11. Industry or business Fairfield Ship Yards

FATHER
12. Name John Wiland
13. Birthplace Md. Garrett Co.

MOTHER
14. Maiden Name Charlotte McIntyre
15. Birthplace Md. Garrett Co.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15. 1944 (month) (day) (year)
(c) Cemetery or crematory Location Frostburg Maryland

18 (a) Funeral director Roth & Bro. C. M. Walter
(b) Address Pratt & Stricker Sts

19 (a) FEB 14 1944 (Date received by local registrar) (b) Huntington Williams, M.D. (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1944 at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 19XX to Feb. 13 19XX and that I last saw h[illegible] alive on Feb. 13 19 44.

Immediate cause of death: Nephritis - probably acute exacerbation of
Due to chronic glomerulo-
Due to nephritis
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M. D.
Address J. H. H. Date signed 2-15

Please write plainly, with ink or indelible pencil. The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14021 Registered No. 84B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Old Glory Beach, Sollers Pt
(b) Street address 223 Light St
(c) Hospital or institution: South Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A.A. Co
(c) City or town Baltimore City, Sollers
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 Light St (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Buckman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma Buckman
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 24 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	6	11		

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Williams Dresslinger
(b) Address Old Glory Beach Sollers Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15, 1944 (month) (day)
(c) Cemetery or crematory Western Cem
Location Balto Md

18 (a) Funeral director A. Howard Evans
(b) Address 1400 N Carey
FEB 14 1944 (Date rec'd by registrar) (b) Huntingtown Williams Md

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1944, at 4 P M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Terminal Pneumonia
Bronchial Pneumonia
Due to Starvation
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hunter S. Tuttle M.D.
Medical Examiner.
Date signed 2/14/44

14022 Original

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 14022
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Rogers Forge--12 - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Murdock Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Kenny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-13-44

8. AGE: Years	Months	Days	If less than one day
			10Hrs. 55 min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name John Joseph Kenny
13. Birthplace Midland Md.

MOTHER
14. Maiden Name Mary Florence Kennedy
15. Birthplace Baltimore Md.

16 (a) Informant John J Kenny
(b) Address 202 Murdock Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore

19 FEB 14 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 2--14--1944 at 7:35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1944, to 2-14 1944 and that I last saw her alive on 2-14 1944.

Immediate cause of death: Congenital Atelectasis — Duration 10 hrs.
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Rogers M. D.
Address 1 W Lexington Street Date signed 2/17/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14023
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 Glenmore Ave (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Joseph Conrad

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age 18y 7m

7. Birth date of deceased (mo., day, yr.) 3 - 1 - 1877

8. AGE: Years: 65 yr | Months: 11 | Days: 12 | If less than one day: hr. 75 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm J Conrad
13. Birthplace Md

MOTHER
14. Maiden Name Mary E Mearl
15. Birthplace

16 (a) Informant Estate
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Leonard & Rusk

18 (a) Funeral director S 305 Harford Rd
(b) Address

19 (a) FEB 14 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-1944, at M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner
Date signed 2-13-44

(over)

14024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14024

Registered No. 836

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Green Spring Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Darrel Hoffman

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Yes - 1st World	219-16-2703	M	W	Married

6 (b) Name of husband or wife Mary (nee Gill)
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 27, 1891

8. AGE: Years	Months	Days	If less than one day hr.	min.
52	6	16		

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Blacksmith Helper
11. Industry or business Bakman Corp. Balto.

FATHER
12. Name Christopher Hoffman
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Anna Lodge
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. W. D. Hoffman
(b) Address Owings Mills Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Texas, Md.

18 (a) Funeral director Louden M. Brooks
(b) Address Sparks Md.

19 (d) FEB 14 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1944 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1944 to 2/14 1944, and that I last saw him alive on 2/14 1944.

Immediate cause of death	Duration
Heart Failure	
Due to Pneumonia	
Due to	
Other Conditions Cerebral Thrombosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles A. Kemper M. D.
Address University Hospital Date signed 2/14

VS 3

14025 449137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. 14025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 550 Robert (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otho MACKAY

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-1944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	MARRIED

6 (b) Name of husband or wife Mabel

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 11-9-84

8. AGE: Years	Months	Days	If less than one day
59	3	2	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER 12. Name Joseph MACKAY

13. Birthplace Md

MOTHER 14. Maiden Name Mamie Wilson

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)

(c) Cemetery or crematory Sams Point

Location Dolts Maryland

18 (a) Funeral director Aspinall & Gaddis

(b) Address 2101 N. Eutaw St

19 FEB 14 1944 (Date received by Local Registrar) (b) Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944 at 838 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1944, to Feb 11 1944, and that I last saw HIM alive on Feb 11 1944.

Immediate cause of death	Duration
Uremia	
Due to Chronic nephritis and Hydronephrosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Bencich

Address J. Hopkins Date signed 2-13

G 14026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14026
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since July 31 1943
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Co.
(c) City or town ~~Baltimore~~ Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 S. 46th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE RYKACZEWSKI

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1899

8. AGE: Years: 45 | Months: 0 | Days: 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Press Shop Worker
11. Industry or business -

FATHER
12. Name Ignatious Rykaczewski
13. Birthplace ? Poland

MOTHER
14. Maiden Name Tillie Stanasysh
15. Birthplace ? Poland

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W Ozazewska
(b) Address 1940 Eastern Ave.

19 (a) FEB 14 1944 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1944 at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31, 1943 to Feb. 13, 1944 and that I last saw him alive on Feb. 13, 1944

Immediate cause of death Syphilitic aortitis with gumma of right ventricle — Duration: Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Paracentesis 8/9/43; 1/11/44; 1/21/44 & 2/10/44

Major findings of operation: Ascitis- clear yellow fluid removed.

Findings of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature

Address Baltimore, Md. Date signed 2/14/44 M. D.

Va-13497

G 14027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 M

G 14027 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira & Linden
(c) Hospital or institution: Md Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 W 37th St (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Mrs Lillie M. Ast

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	m

6 (b) Name of husband or wife John F. Ast
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 25-1875

8. AGE: Years	Months	Days	If less than one d.
68	6	17	hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business —

FATHER
12. Name Richard Dawn
13. Birthplace Md

MOTHER
14. Maiden Name Mary Ellen Frank
15. Birthplace Md

16 (a) Informant John F. Ast
(b) Address 810 W. 37th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15-1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3691 Falls Road (b) Huntington Williams, M.D. Registrar

FEB 14 1944 (Date received by Registrar)

V8 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1944, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1944, to 2-12 1944, and that I last saw h[illegible] alive on 2-12 1944.

Immediate cause of death carcinomatosis — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Thompson M. D.
Address Md. Gen'l Hosp. Date signed 2/12/44

G 14028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14028
Registered No. 1700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1411 Division Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thon (Cloon) Frances Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1944, at 4:20 P.M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1935

8. AGE: Years	Months	Days	If less than one day
8	9	1	hr. min.

9. Birthplace Brta. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name George Young
13. Birthplace Md

MOTHER 14. Maiden Name Catherine Young
15. Birthplace Md

16 (a) Informant: Catherine Young
(b) Address 1411 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott wife
(b) Address 1292 N. Carolina Street

Date received FEB 14 1944 (Huntington Williams, M.D. Registrar)

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 14/2

(a) Date of injury 2-11-44 M.
(b) Where did injury occur? Lafayette & Division
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian Struck by truck

23. Signature H. Z. Wollenmeber M.D., Medical Examiner.
Date signed 2-12-44. while sleep. wkg.

VS 151

C 14029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 B

Registered No. C 14029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 N. Dunbar St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hicks
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	married

6 (b) Name of husband or wife Carrie Hicks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day hr	min.
40				

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Davis Hicks
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Evans
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location G. C. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Carrolton Ave.

FEB 14 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

15

20. DATE OF DEATH February 13 1944 at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1944 to Feb. 13 1944 and that I last saw him alive on Feb. 13 1944.

Immediate cause of death	Duration
Lepto-dyg Failure	
Due to Pulmonary infection	
Due to Rheumatic Heart disease & auricular fibrillation, M.S.	
Other Conditions M.S. - failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cohen M. D.
Address J. Hopkins Date signed 2-13

G 14030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G 14030

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Harford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Early

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Abner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1884

8. AGE: Years	Months	Days	If less than one day
59	11	4	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Paul Dean
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Victoria
15. Birthplace Va.

16 (a) Informant Abner Early
(b) Address 1114 Harford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location D. C. County Md.

18 (a) Funeral director Mrs. Albert S. Elliott & Dgt.
(b) Address 1129 N. Eutaw St.
(c) Date filed by registrar FEB 14 1944 Wellington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1944 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1928 to Feb 10 1944 and that I last saw h. alive on Feb. 6 1944.

Immediate cause of death Carcinoma of the Breast — Duration 6 months

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Reckless M.D.
Address 426 N. Gilmor St Date signed 2/11/44

G 14031

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 14031
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and the town)
(d) Street No. 833 Orleans Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hillie R. Huff

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1927

8. AGE: Years	Months	Days	If less than one day
16	6	19	hr. min.

9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Huff
13. Birthplace N. C.

MOTHER
14. Maiden Name Beatrice Covington
15. Birthplace N. C.

16 (a) Informant John Huff
(b) Address 1833 Orleans St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 15, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Chesaw S. Carolina

18 (a) Funeral director Mrs. Robert A. Elbert & Off.
(b) Address 129 N. Carolina St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 14 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1944, at 6:35 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-11-44 at 2:15 P. M. 7/4
(b) Where did injury occur? 908 N. Durham St.
(c) Did injury occur at home, on farm, industrial place, in public place? Friend's Home. While at work? No.
(d) Means of injury: Shot with a 32 colt automatic pistol

23. Signature H. Z. Wallenmeier M.D.
Medical Examiner.
Date signed 2-12-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G 14032 Registered No.

Respect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 539 N. Washington street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) -- 7 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 539 N. Washington (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE WILLIAM SNYDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Mae Bullock Snyder
6 (c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) Oct. 13, 1880

8. AGE: Years	Months	Days	If less than one day
63	3	28	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name George William Snyder
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Roberts
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mae Bullock Snyder
(b) Address 539 N. Washington street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) ..... (Date rec'd by registrar) (b) Huntington Mills, Md.
FEB 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1944 at 9-16 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1943 to Feb 11 1944, and that I last saw him alive on Feb 11 1944.

Immediate cause of death Carcinoma of Larynx — Duration 6 months
Due to .....
Due to .....
Other Conditions Carcinomatosis —
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature E. Gill Hall
Address 1631 North ave Date signed M. D. Feb 12 44

G 14033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14033 X 47C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution:
~~Baltimore~~ University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County —
(c) City or town Thomasville
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mae C. Hostetter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Omar L. Hostetter

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 31 | Months | Days | If less than one day hr. min.

9. Birthplace Idaho
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Arthur M. Horbeck
13. Birthplace Michigan

MOTHER
14. Maiden Name Bessie Dustin
15. Birthplace Wisconsin

16 (a) Informant Husband (Omar L. Hostetter)
(b) Address Thomasville, Pa.

17 (a) Burial (b) Date thereof 2/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory York
Location York R.D. Pa.

18 (a) Funeral director Melvin Santee
(b) Address Spangroave Pa

19 (a) (b)
(Date received by registrar) Registrar

FEB 14 1944 Hanover, York, Pennsylvania

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1944, at 3:20 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 27, 1944 to Feb. 14 1944, and that I last saw her alive on Feb. 14, 1944.

Immediate cause of death
Medullary failure due to metastatic carcinoma - left temporal lobe of brain — Duration

Due to Bronchogenic carcinoma of left lung with abscess

Due to

Other Conditions Metastatic carcinoma to right lung. CA liver
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Saint

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R.A.C.

Address Mun. Hosp. Date signed 2/14

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G 14034
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Washington Blvd.
(c) Hospital or institution: Provident Hosp. [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 [illegible]
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [illegible]
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-07-9694

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known ?

8. AGE: Years | Months | Days | If less than one day: hr. min.
About 60

9. Birthplace Kretingos, Russia
(town, county, and state)

10. Usual Occupation Tailor
11. Industry or business Clothing

FATHER
12. Name not known
13. Birthplace Lithuanian

MOTHER
14. Maiden Name not known
15. Birthplace Lithuanian

16 (a) Informant Mrs Selma Salkovich
(b) Address 819 Hollins St

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Feb 15-44 (Month, day, year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John C. Gatlin & Sons
(b) Address 423 S. Paca St

19 (a) FEB 14 1944 (Date rec'd by registrar)
(b) [illegible] Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7/44, 19 , at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Coronary Thrombosis

Due to (b)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner

Date signed 2-7-44

G 14035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14035 Registered No. 944

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Mary's Industrial School
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Mary's Industrial School
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Raymond Matteo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose Viagro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr	min
48				

9. Birthplace Baltimore, Md.
(Town, county and state)

10. Usual Occupation Watchman
11. Industry or business St. Mary's Industrial School

FATHER
12. Name Frank P. Matteo
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Rose Clara Matteo
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Clara Burroughs
(b) Address Macomia Rd Alexandria Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington, Va

18 (a) Funeral director Arlington, Va.
(b) Address Joseph E. Gormley 809 Kmgsst Alexandria

19 (a) Date rec'd by registrar FEB 14 1944 (b) Registrar
VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1944 at 3:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed February 14, 1944

G 14036

BALTIMORE CITY HEALTH DEPARTMENT G 14036 **Registered No.**

CERTIFICATE OF DEATH 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 W Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 W Lexington St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Innstall Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Negro	Widowed

6 (b) Name of husband or wife James Robinson (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 29, 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	6	5	12	

9. Birthplace Mecklenburg Va (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Joyce Courtney
13. Birthplace Va

MOTHER 14. Maiden Name Wilson
15. Birthplace

16 (a) Informant Lucy Innstall
(b) Address 1133 Druid Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14th/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery
Location Cedar Hill Md

18 (a) Funeral director Edw O Wilson
(b) Address 1000 Brantley Ave

19 (a) Filed FEB 14 1944 (b) (Date filed by registrar) Registrar

VS 150

Huntington Williams 11:5

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1944, 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1943 to Feb 10 1944 and that I last saw him alive on Feb 10 1944.

Immediate cause of death | **Duration**

Adenocarcinoma of Colon | 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Watts M.D.
Address 754 Lexington Ave Date signed 2/14/44

Copy at age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14037 Registered No. 107

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Fon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Fon Ave (Rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Elizabeth Harvey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Freeman Harvey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1872

8. AGE: Years 7 | Months 7 | Days 6 | If less than one day: hr. min

9. Birthplace Deinwiddie, Va (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Henry Epps

13. Birthplace Va.

MOTHER 14. Maiden Name Persanna Richards

15. Birthplace Va.

16 (a) Informant Lurania Epps

(b) Address 2556 Mad. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Elroy Hudson

(b) Address 1000 Brantford Ave

(a) (b) Huntingtor Williams

FEB 14 1944

(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 19XX, at 7 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 19XX to Feb 10, 19XX and that I last saw h[illegible] alive on Feb 9, 19XX

22. Immediate cause of death

Bronchopneumonia — Duration: 1 wk

Due to

Due to

Other Conditions

Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Maurice Adams M. D

Address 312 E 23rd St

Date signed 2-14-44

443 11038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 18

Registered No. 11038

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Penn~~ Pa. (b) County
(c) City or town Williamsport (If outside city or town limits write RURAL and give town)
(d) Street No. 628 Greene St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Cooper
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Sue Cooper
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) about 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Miriam Cooper
13. Birthplace Pa

MOTHER
14. Maiden Name Mary Talbert
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ~~Burial, cremation,~~ or removal (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Williamsport Penna
Location

18 (a) Funeral director William Cook Jr
(b) Address 1217 St. Paul St

19 (a) FEB 14 1944 (Registrar's signature) Wm. A. Williams, M.D.
(b) (Date received by registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1944 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1943 to Feb. 13 1944 and that I last saw h on alive on Feb. 13 1944

Immediate cause of death Carcinoma of prostate with extension to bladder, rectum & lymph nodes — Duration 1½ yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell R. Reed M. D.
Address Johns Hopkins Hosp. Date signed 2/15/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14039
Registered No.

131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Neal Brown
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	black	married

6 (b) Name of husband or wife
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
45			hr min

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Neal Brown
13. Birthplace

MOTHER
14. Maiden Name Fanni Williams
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 2-16-44 (month) (day) (year)
(c) Cemetery or crematory Rocky Mt. N. C.
Location Rocky Mt. North Carolina

18 (a) Funeral director W. H. Nelson
(b) Address 1303 Prentiss St. Huntington Pittsburgh, Pa.

19 (a) (Date rec'd by registrar) Registrar

FEB 14 1944
VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1944 at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1944 to Feb 13 1944 and that I last saw h alive on Feb 13 1944

Immediate cause of death: Respiratory Failure — Duration
Due to Hypertensive encephalopathy
Due to malignant arteriolar nephrosclerosis
Other Conditions uremia

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Glucein M.D.
Address J. Hopkins Date signed 2-15-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 14040
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4600 O'Donnell St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Deady Deady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3rd 1944

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John E. Deady
13. Birthplace Md

MOTHER
14. Maiden Name Della Wilson
15. Birthplace W. Va

16 (a) Informant Mr John Deady
(b) Address 4600 O'Donnell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15th 1944 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Seymour Hill Rd

18 (a) Funeral director Leo D. Cook
(b) Address 1701-03 N Patt Park Blvd

19 (a) FEB 14 1944 (Date received by Registrar) (b) Registrar
Huntington Williams, MD

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1944 at 1 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1944 to Feb 13 1944 and that I last saw him alive on Feb 13 1944.

Immediate cause of death	Duration
Bilateral Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Wallace M.D.
Address 1400 N. Caroline St Date signed 2/15/44

14041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41 G 14041 Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Norfolk Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Norfolk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Baruch Siegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Klara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April, 15, 1879

8. AGE: Years	Months	Days	If less than one day
64	9	29	hr. min.

9. Birthplace Rumania (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired Merchant

FATHER 12. Name Leon Siegel
13. Birthplace Russia

MOTHER 14. Maiden Name Cherna ?
15. Birthplace Russia

16 (a) Informant Mrs Rose S. Waghelstein
(b) Address 2908 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location Mt Carmeel Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

FEB 15 1944 (Date received by local registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14 1944, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9- 1944, to 2-14-1944, and that I last saw h alive on 2-13- 1944.

Immediate cause of death	Duration
Cardiac failure	3 days
Due to C.V.S. Hyp. Dis	1 yrs.
Diabetes Mellitus	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Waghelstein M. D.
Address 2 E. Madison St Date signed 2-14-44

G 14042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G 14042
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3912 W. Garrison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernetti Fulgenzi

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Thelma Fulgenzi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
26			hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Burner
11. Industry or business Bethlehem Steel

FATHER
12. Name Cichetti Fulgenzi
13. Birthplace Italy

MOTHER
14. Maiden Name Nancy Fegatini
15. Birthplace Italy

16 (a) Informant Wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16/44 (month) (day) (year)
(c) Cemetery or crematory
Location Wembley Pa

18 (a) Funeral director Wm. J. Fyfe & Sons
(b) Address North & Eager Sts. Huntington Pittsburgh, Pa.

19 (a) FEB 15 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1944, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1944 to death 19..., and that I last saw him alive on 2/14 1944.

Immediate cause of death	Duration
Cerebral embolus	30 min.
Due to Cardiac dilatation & hypertrophy, cardiac failure	"
Due to Rheumatic cardiovascular disease	14 yrs.
Other Conditions	"

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. A. Simmonton M. D.
Address University Hosp. Date signed 2/15/44

VS 3

14043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14043
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1417 E. Madison Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Stewart
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M.
5. Color or race Co
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Taina Stewart
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1886
8. AGE: Years 57 Months - Days - If less than one day hr. min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Stewart
13. Birthplace Va

MOTHER
14. Maiden Name Louise ?
15. Birthplace Va

16 (a) Informant Mrs Taina Stewart
(b) Address 1417 E Madison St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 19 (day) 44 (year)
(c) Cemetery or crematory Mt Calvary Location Brooklyn Md
18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St
19 (a) Filed FEB 15 1944 (Date rec'd by Registrar) Clifton Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 : 13 1944 at 7:40 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2 1944 to 2-13 1944 and that I last saw h alive on 2-13 1944.

Immediate cause of death
Pulmonary edema
Acute myocarditis
Due to Chr. Nephritis
Due to La Grippe
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1 Day
1 Day
8 wks.
2 wks.

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Dow L. Berry M. D.
Address 1420 6 Chase Date signed 2-14-44

G 14044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14044 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 North Fulton Ave (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country ? Turkey

3 (a) FULL NAME Henry Lowenstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3 1868

8. AGE: Years	Months	Days	If less than one day
75	2	11	hr min.

9. Birthplace Constantinople (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Henry Lowenstein
19. Birthplace Turkey

MOTHER 14. Maiden Name Fanny Lipmen
15. Birthplace Turkey

16 (a) Informant Adolph Lowenstein
(b) Address 806 White Oak St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-44 (month) (day) (year)

(c) Cemetery or crematory Southern Ave
Location Same

18 (a) Funeral director Jos. Levi Inc
(b) Address 1439 E. Baltimore St.

FEB 15 1944 (Date rec'd by registrar) Huntington Williams Inc (Signature of funeral director)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14-1944 at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1944 to 1-14 1944 and that I last saw him alive on 1-14 1944

Immediate cause of death Myocardial Infarction — Duration 1 day

Due to Arteriosclerotic Heart Disease — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Church Home Hospital Date signed 2/14/44 M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 14045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Aron Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Aron Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarrie Mae Harding

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widow

6 (b) Name of husband or wife: late George W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1867

8. AGE: Years	Months	Days	If less than one day
76	9	5	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John W. Ashbrook
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elizabeth Keller
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Pearl Saurhoff
(b) Address 3207 Aron Ave

17 (a) Burial (b) Date thereof 2/17/44
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount & North.

18 (a) Funeral director Harry H. Witzke
(b) Address 410 Edmondson Ave

FEB 15 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1944 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1938 to Feb 14 1944 and that I last saw her alive on Feb 7 1944.

Immediate cause of death: Chronic myocarditis — Duration: 5 years
Due to
Due to
Other Conditions: Multiple Arthritis — 8 years

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence none at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury none

23. Signature L. L. Cordy M. D.
Address 5106 Harford Rd Date signed 2-15-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14046 CARTER ✓ 107 G 14046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N.
(b) Street address 917 Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balt. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Lanvale St
(If no street give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Carter, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/26/43

8. AGE: Years | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Carter, Sr.
13. Birthplace Norfolk, Va

MOTHER
14. Maiden Name Pearl Walker
15. Birthplace Balto Md

16 (a) Informant Pearl Carter
(b) Address 917 Lanvale St

17 (a) Burial (b) Date thereof 2/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet,
Location A. I. Co. Md.

18 (a) Funeral director Chas H. Alexander
(b) Address 927 N. Mount St

19 (a) Date received FEB 15 1944 (b) Registrar Hunter Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12/1944 2:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11/44 to 2/12/44, and that I last saw h[illegible] alive on 2/12/44.

Immediate cause of death Pneumonia Bronchial
Due to Cold

Duration 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Lee Ellen M. D.
Address 724 Madison Date 2/14/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

G 14047
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2713 Kirk Ave.
(c) Hospital or institution: ********
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 Kirk Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Elizabeth Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-2332

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George A Brown
6 (c) If alive, give age *** years

7. Birth date of deceased (mo., day, yr.) June 27 1875

8. AGE: Years	Months	Days	If less than one day
68	7	16	....hr. ....min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Paper Box Manufacturing

FATHER
12. Name John Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Baltis
15. Birthplace Baltimore

16 (a) Informant Myrtle M Jenkins
(b) Address 2713 Kirk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave.

19 FEB 15 1944 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Feb 12 1944 and that I last saw h[er] alive on Feb 12 1944.

Immediate cause of death	Duration
Hypertensive Cardiac disease	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irvin J. Munger M. D.
Address 2700 Harford Rd Date signed Feb 15

VS 3

1944

14048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 14048

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Calverton Heights (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Jones (Peter William Jones)

3 (b) If veteran, name war: -- 1st World War
3 (c) Social Security Account No. --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1888

8. AGE: Years: 55 | Months: 5 | Days: -- | If less than one day: hr. min.

9. Birthplace: Edwardsville, Pa. (Town, county, and state)
10. Usual Occupation: Guard - Edgewood Arsenal
11. Industry or business: U. S. Gov't.

FATHER
12. Name: Wm. Jones
13. Birthplace: Wales

MOTHER
14. Maiden Name: Catherine
15. Birthplace:

16 (a) Informant: Mrs. Mary B. Jones
(b) Address: 2310 Calverton Hgts. Ave. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat'l. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) FEB 15 1944 (Date rec'd by registrar) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/44 19 at 11:35 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb. 14 1944

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 14049
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home + Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34 E 25th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cyrus D Sadler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Beatrice Sadler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 10 19

8. AGE: Years 64 | Months 2 | Days 3 | If less than one day hr min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER
12. Name Octavius Ryland Sadler
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Alice Otey
15. Birthplace Virginia

16 (a) Informant Mrs. Beatrice Sadler
(b) Address 34 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery or crematory
Location Chestertown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 15 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 19 44, at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 19 44, to 2-13 19 44, and that I last saw him alive on 2-13 19 44.

Immediate cause of death Bronchopneumonia — Duration 1 wk

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J M Cuellar M. D.
Address Church Home Hospital Date signed 2-13-44
Baltimore, Md.

Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

14050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 121a

G 14050 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25 S. ELLWOOD AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) LIFE
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) no
If yes, name country

3 (a) FULL NAME EMMA HENRIETTA RAITHER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: JOHN ADAM RAITHER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 10 1865

8. AGE: Years 78 | Months 5 | Days 2 | If less than one day: hr. min.

9. Birthplace BALTO MD (Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name CARL ROESNINCK
13. Birthplace GERMANY

MOTHER
14. Maiden Name JOHANNAH MOHR
15. Birthplace GERMANY

16 (a) Informant MRS WM T WATSON
(b) Address 25 S ELLWOOD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2 16 44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location BALTO CO. MD

18 (a) Funeral director HENRY SANDER&SONS INC
(b) Address NORTH AVE&BROADWAY

19 (a) FEB 15 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1944 at 7.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-2 1937 to Feb 12 1944, and that I last saw h-r alive on Feb 12-1944

Immediate cause of death: Myocardial Insufficiency — Duration: 1 day
Due to: Pulmonary Edema
Due to: Chronic Interstitial Nephritis
Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. G. Leyson M.D.
Address 1504 Maltondale Date signed 2/15/44

VS 350

14051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

Registered No. G 14051

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Lanvale Line
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Presman Ave
(Rural give location)
(e) Citizen of foreign country? Russian (Yes or No)
If yes, name country

Mary E. Allen

3 (a) FULL NAME Allen, Mrs. Mary E

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Allen, Paul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7, 1911

8. AGE: Years	Months	Days	If less than one day
33 yrs		6	hr. min.

9. Birthplace Indiana
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lavender
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Underwood
15. Birthplace —

16 (a) Informant Mr. Paul E. Allen
(b) Address 502 Presman Ave, Balt. MD.

17 (a) Burial (b) Date thereof 2/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location 2930 Frederick Ave

18 (a) Funeral director William H. Mareck
(b) Address 713 Light St

19 (a) FEB 15 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1944, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1944 to Feb 13 1944, and that I last saw her alive on Feb 13 1944.

Immediate cause of death Pulmonary Tbc — Duration 2

Due to

Due to

Other Conditions Bronchopneumonia
Tbc nephritis (bilat.)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Steven Natcher, M. D.
Address 2730 Date signed 2-15-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

14052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109

G 14052 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6 + 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 - 31 - 43

8. AGE: Years | Months: 8 | Days: 10 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name Henry Brooks
13. Birthplace Baltimore, Md
14. Maiden Name Doris Hampton
15. Birthplace Baltimore, Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md

18 (a) Funeral director Dunnard A. Covington
(b) Address 21 W 25th St.

19 (a) FEB 15 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1944, to Feb 11 1944, and that I last saw her alive on Feb 11 1944.

Immediate cause of death Cardiac failure — Duration
Due to pneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)

over

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger Kelly
Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

14053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 Registered No. G 14053

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4507 Kathleen Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4507 Kathleen Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes G Norfolk

3 (b) If veteran, name war: No | 3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph C Norfolk. If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1858

8. AGE: Years 85 | Months 5 | Days 15 | If less than one day hr min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

MOTHER / FATHER
12. Name (Mother) Osborne
13. Birthplace Md
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs A. L Jones
(b) Address 4507 Kathleen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Wilhelm & Moore
(b) Address 1217 E Lombard St

FEB 13 1944

19 (a) (Date rec'd by registrar) (b) Huntington (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1944 at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Feb 12 1944 and that I last saw her alive on Feb 12 1944

Immediate cause of death: Old Age — Duration:

Due to Arteriosclerosis — 4 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Smith M. D.
Address 4509 Liberty Hgts Date signed Feb 14

VS 150

8

14054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

V G 14054

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1902 Bolton St

(If rural give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country

3 (a) FULL NAME Compton, David

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of ~~husband or~~ wife Ruth Compton

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept 22nd 1876

8. AGE: Years	Months	Days	If less than one day
67	4	21	hr. min.

9. Birthplace Middletown N.Y.

(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Farming & Construction

FATHER

12. Name Harmon Compton

13. Birthplace Unknown

MOTHER

14. Maiden Name Emma Crouk

15. Birthplace Unknown

16 (a) Informant Mrs Ruth Compton

(b) Address 1902 Bolton St

17 (a) Removal (b) Date thereof 2/15/44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Dunmore Pa.

Location

18 (a) Funeral director William Cook Inc

(b) Address 1347 St. Paul St.

19 (a) FEB 15 1944 (b) Huntington Pennsylvania

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1944, at 9 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1944 to 2/13 1944

and that I last saw him alive on 2/13 1944

Immediate cause of death Uremia — **Duration**

Due to Pulmonary pyonephrosis

Due to Prostatic hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/10/44 & 2/12/44

Major findings of operation: Prostatic hypertrophy

of autopsy: Pyonephrosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Irving Lebedun

Address Sinai Hospital Date signed 2/14

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G 14055 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 763 Carroll St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 763 Carroll St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm. Henry Grace

3 (b) If veteran, name war — World War I

3 (c) Social Security Account No. 218-10-1222

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: GRACE E GRACE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 3-1896

8. AGE: Years 47 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace BALTO. MD (Town, county, and state)

10. Usual Occupation CARPENTER

11. Industry or business Glen L Martin

FATHER — 12. Name John Grace
13. Birthplace Balto Md

MOTHER — 14. Maiden Name Clara Parks
15. Birthplace Balto Md.

16 (a) Informant GRACE E GRACE
(b) Address 763 CARROLL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB-16-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md

18 (a) Funeral director Bernard C. Hahn
(b) Address 12 E West St

19 FEB 15 1944 (Date rec'd by registrar) per Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1944 at 930 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1944 to Feb 13 1944
and that I last saw h alive on Feb 13 1944

Immediate cause of death — Duration

Due to Acute Dilatation of Heart

Due to

Other Conditions Malignancy of Lung

(Include pregnancy within 3 months of death)

Date of operation Jan 6. 44

Major findings of operation: Inoperable

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. L. Lichtenberg

Address 1111 Madison Ave Date signed 2/15/44

VS 180

14056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 14056

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 E Monument St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 E. Monument (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	col	widow

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Aberdeen Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Md

MOTHER 14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mary Still
(b) Address 1610 E Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-44 (month) (day) (year)
(c) Cemetery or crematory Mayotte Cemetery
Location Joppa Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date received) FEB 17 1944 (b) (Registrar) Huntington Williamsville

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1943 to Feb 13 1944, and that I last saw h[illegible] alive on Dec 12 1943

Immediate cause of death

Due to Arteriosclerosis

Due to Apoplexy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Bishop M. D.
Address 1612 E Monument Date signed Feb 14/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14057 Registered No. 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD HENDERSON BAILEY.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Child

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-24-1938

8. AGE: Years	Months	Days	If less than one day
5	6	18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Ernest Bailey

13. Birthplace Md

MOTHER 14. Maiden Name Blanch Clark

15. Birthplace Md

16 (a) Informant Blanch Bailey

(b) Address 1131 Shields Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 16 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania ave

19 (a) FEB 15 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1944, at 6 a.m. M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy thereon and from the evidence (Autopsy or Inquiry) obtained by said " (Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

Immediate cause of death Atelectasis, right lung — Duration

Due to Crushing of chest (compression)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 7/2

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Feb 8 1944 at 3:30 M

(c) Where did injury occur? Hagerstown (City or town) Washington (County) Md (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Institution (Specify type of place) While at work? Yes

(e) Means of injury Pedestrian struck by auto

23. Signature W. J. Wallenmeyer M.D. Medical Examiner.

Date signed 2-12-44

VS 6

14058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14058

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 W. University Pkwy
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 13 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town City of Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 W. University Pkwy (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Reginald Bragonier

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary G. Bragonier
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 7/24/1875

8. AGE: Years 68 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Oil Business

FATHER 12. Name Alfred C. Bragonier
FATHER 13. Birthplace Frederick Co., Md.

MOTHER 14. Maiden Name Elizabeth Rebecca McGee
MOTHER 15. Birthplace Not Known

16 (a) Informant Mrs. Mary G. Bragonier (wife)
(b) Address 611 W. University Pkwy.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-15-44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto., Md.

18 (a) Funeral director STEWART & MOWEN COMPANY (F. WOODEN SUC.)
(b) Address 108 W. NORTH AVENUE

19 (a) FEB 15 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1944, at 2 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1939, to Feb 13 1944, and that I last saw h[e] alive on Feb 9 1944.

Immediate cause of death: Chronic Myocarditis — Duration many years
Due to Bronchial Asthma — many years
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Francis W. Gluck M. D.
Address 715 Park Ave Date signed 2/14/44

Lyles

G 14059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. G 14059

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 15 14 Division 15th

(c) Hospital or institution: Provident

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1372 n Calhoun (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) **FULL NAME** Lee Lyles 1372 n Calhoun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	Negro	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Howard Co Maryland (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name Martha Tyles

15. Birthplace Howard Co.

16 (a) Informant Lem Lyles

(b) Address 824 mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)

(c) Cemetery or crematory mt Auburn

Location Md

18 (a) Funeral director Geo. H. Kelsor

(b) Address 1303 Preastman st

19 (a) [illegible] (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1944 at 7.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1944 to 2-13 1944 and that I last saw him alive on 2-13 1944.

Immediate cause of death Pyelonephritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bernard Hamm M. D.

Address 1207 N Caroline Date signed 2-14-44

FDS

VS 250

14060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14060

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia A. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Jesse
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 12/10/1893

8. AGE: Years	Months	Days	If less than one day
50	2	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Housewife

FATHER
12. Name Sepia Conyer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Laura
15. Birthplace Md

16 (a) Informant Jesse Smith(Husband)
(b) Address 1413 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) FEB 15 1944 (Date received by Registrar) (b) Theodore Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1944, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944 to Feb 11 1944 and that I last saw him alive on Feb 11 1944.

Immediate cause of death Bronchio-Pneumonia — Duration 11 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Watts M. D.
Address 515 Carlington Date signed 2/14/44

G 14061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G 14061 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 E. 24th St.
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 E. 24th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence J. Michaux.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-07-9929

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna Michaux

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1884

8. AGE: Years	Months	Days	If less than one day
59	8	8	hr. min.

9. Birthplace Baltimore - (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Laboratory Glass work.

FATHER
12. Name John Michaux
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Brem
15. Birthplace Baltimore Md.

16 (a) Informant Catherine L. Swiecz
(b) Address 609 E. 24th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location G. G. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1420 Light St

19 (a) (Date received by local registrar) (b) Registrar Huntington Williams M.D.

FEB 15 1944

No. 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1944 at 3 00 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10 1 1943 to 2 14 1944, and that I last saw h alive on Feb. 14 1944

Immediate cause of death Carcinoma of Rt lung with metastases to left lung

Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 1943

Major findings of operation: Carcinoma Rt lung

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith M.D.

Address 1223 E. North Ave Date signed 2/16/44

G 14062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14062 Registered No. 121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2325 Madison Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Madison Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Cotton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife Betty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1893

8. AGE: Years 50 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Louis Cotton
13. Birthplace N. C

MOTHER
14. Maiden Name Viola Battle
15. Birthplace N. C

16 (a) Informant John Cotton
(b) Address 924 Harlem Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Plymouth, N. C.
Location

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Druid Hill Avenue

19 (a) FEB 15 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1944, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1943 to Feb 13 1944 and that I last saw him alive on Feb 13 1944

Immediate cause of death

	Duration
Cardio Vascular Renal Disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Stephens M. D.
Address 1413 Druid Hill Ave Date signed

G 14063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14063 / 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 Robert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Robert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Estelle Fennell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife James A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1872

8. AGE: Years	Months	Days	If less than one day
91 72	10	-	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name Henry Cummings
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Savage
15. Birthplace Maryland

16 (a) Informant Eliza Higginbotham
(b) Address 304 Robert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Mrs. Chas. H. Holland
(b) Address 1631 Druid Hill Ave. Baltimore (Filed) Md.

FEB 15 1944 (b) 6
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9 1944 at 6.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1944 to 2-9 1944
and that I last saw h.er alive on 2-9 1944

Immediate cause of death: Coronary occlusion — Duration: Sev. hours

Due to: chronic myocard.tis

Due to:

Other Conditions: diabetes mell.tus.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature K. Browne

Address 1311 E. Madison St Date signed 2/12

VS 150

G 14064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14064

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Jasper L. Haten

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Colored	Widower

6 (b) Name of husband or wife Etta B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1879

8. AGE: Years	Months	Days	If less than one day
65	1	2	hr. min.

9. Birthplace Arden, N. C. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary L. Holmes
(b) Address 1709 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. George H. Stallard
(b) Address 1631 Druid Hill Ave.

FEB 15 1944 (Date rec'd by registrar) (b) Huntington Williams Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 13 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1944, to Feb 13 1944, and that I last saw him alive on Feb 13 1944

Immediate cause of death Cerebral Hemorrhage — Duration Feb 9/44

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Pillet M. D.
Address 817 Hamilton Ave. Date signed

G 14065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 14065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2453 Francis St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2453 Francis St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie R. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1882

8. AGE: Years	Months	Days	If less than one day
62	-	15	hr. min.

9. Birthplace Sandy Springs, Md. (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Mr. Reddy
13. Birthplace Montgomery Co. Md.

MOTHER
14. Maiden Name Jennie Matthews
15. Birthplace Montgomery Co. Md.

16 (a) Informant Theresa Cook
(b) Address 2453 Francis St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Sandy Spring, Md.

18 (a) Funeral director Mrs. Chas. W. Holland
(b) Address 1631 David Hill Ave.

19 (a) Filed (Date received by registrar) FEB 16 1944 (b) Registered by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1944 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1944 to Feb. 12 1944 and that I last saw her alive on Feb. 12 1944.

Immediate cause of death Cerebral Hemorrhage — Duration Days 1/4

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Peltekian M. D.
Address 817 Hamilton Date signed

H. C. PELTEKIAN.

G 14066

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14066 Registered No. 46H

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6532 Rosemont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Lurz KATHARINE U. LURZ

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John H. Lurz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1889

8. AGE: Years 55 | Months 1 | Days 12 | If less than one day 15 hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Charles Zeller
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Langhirt
15. Birthplace Germany

16 (a) Informant Miss Frances M. Lurz
(b) Address 6532 Rosemont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17th 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leadon Funeral Home
(b) Address 7401 Belair Road

19 (a) FEB 17 1944 (Date registered) (b) Huntington Williams, M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1944. at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1944, to Feb 13 1944, and that I last saw her alive on Feb. 13, 1944.

Immediate cause of death: Circulatory Collapse — Duration

Due to Generalized Carcinoma

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Retroperitoneal Neoplasm & generalized metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County), (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. E. Hornbrook M. D.
Address Mercy Hospital Date signed 2/13/44

G 14067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 14067

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 E. 33d Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E. 33d Street (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Edwin Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Crowther
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1874

8. AGE: Years	Months	Days	If less than one day
70	0	22	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name John P. Carter
13. Birthplace Connecticut

MOTHER
14. Maiden Name Maria Watkins
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Anna C. Carter
(b) Address 5 E. 33d Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

FEB 15 1944 (b) Huntington Williams, M.D.
(Registrar's signature)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1944, at 11-58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1943 to Feb 14 1944, and that I last saw him alive on Feb 14 1944.

Immediate cause of death: Lobar Pneumonia — Duration 2 days
Due to Arteriosclerosis — 4 yrs
Due to Left Hemiplegia Cerebral Hemorrhage — 7 mo
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Gibson Porter M. D.
Address 4822 Roland Ave Date signed 2/15/44

G 14068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14068 / 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 920 Tyson St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days) 13

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 920 Tyson St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 72 | Months | Days | If less than one day hr. min

9. Birthplace Hartford Co. Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Anna Brooks

(b) Address 920 Tyson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

FEB 15 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1944 at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Feb 11 1944, and that I last saw alive on Feb 11 1944

Immediate cause of death	Duration
Cardio-Renal Disease	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Irene D. Johnson M.D.

Address 2329 Jeanes St Date signed Feb 14 1944

G 14069

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14069 Registered No. 200a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Calvert Street
(c) Hospital or institution: Mercy Hospital 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Woodlea Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. John Kugel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Hattie V. Kugel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 / 18 / 1875

8. AGE: Years	Months	Days	If less than one day
68 69	7 4	5 25	— hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Kugel-
13. Birthplace Germany

MOTHER
14. Maiden Name Alice Wattenberg
15. Birthplace Germany

16 (a) Informant Mrs F. Wettengel
(b) Address 3514 Woodlea Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Edward S. MacNabb
(b) Address Frederick & Wade Aves.

FEB 15 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 / 13 / 44 19 . at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 19 44 to 2/13 1944, and that I last saw him alive on 2/13 19 44

Immediate cause of death Cardiac Respiratory Failure — Duration 3 Days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence . at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. B. McCadden M. D.

Address Date signed

VS 150

G 14070

G 14070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3646 Coolidge Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3646 Coolidge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Singuru Burkhead Babbitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

(b) Name of husband or wife Pearl Bowen Babbitt
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 7-1890

8. AGE: Years	Months	Days	If less than one day
53	9	6	hr. min.

9. Birthplace Raleigh - North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Hal Babbitt
13. Birthplace North Carolina

MOTHER
14. Maiden Name May Burkhead Conway
15. Birthplace North Carolina

16 (a) Informant Pearl Bowen Babbitt
(b) Address 3646 Coolidge Ave-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-15-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) 2-15-1944 (Date received by registrar) (b) Huntington Nicholas, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Feb 13 1944 and that I last saw h.. alive on Feb 1st 1944.

Immediate cause of death 1 coronary thrombosis — Duration 8 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos J Corbett M. D.
Address 4509 Liberty Heights Ave Date signed 2-15-44

VS 3

G 14071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14071 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6601 Hampstead Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT J. KOCK

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-2321

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Ruth E. Kock

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) October 10, 1902

8. AGE: Years	Months	Days	If less than one day
41	4	4	hr. min.

9. Birthplace Patterson, Pa. (Town, county, and state)

10. Usual Occupation Chemical Eng.

11. Industry or business Pa. Water & Power Co.

FATHER
12. Name H. John Kock
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mattie Stelly
15. Birthplace Kentucky

16 (a) Informant Mrs. Ruth E. Kock
(b) Address 6601 Hampstead Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19. 44 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran Cem
Location Spring City Pa

18 (a) Funeral director Clarence F. Bauer
(b) Address 5305 Hamilton Blvd

19 (a) FEB 15 1944 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14, 1944, at 6:50 P M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D.
Medical Examiner.
Date signed 2-15 1944

VS 151

G 14072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V107

G 14072 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 434 Oxford Ct.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	newborn

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-4-44

8. AGE: Years	Months	Days	If less than one day
5 days		5	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name William Cornish
13. Birthplace Centreville Md

MOTHER
14. Maiden Name Burnell Johnson
15. Birthplace Brandywine Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 15 1944 Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7- 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4- 1944 to 2-7- 1944. and that I last saw him alive on 2-6- 1944

Immediate cause of death

Duration
1 Bronchial Pneumonia
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. St. Butler M. D.
Address President Hospital Date signed 2/10/44

VS 150

0726

G 14073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 14073 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Woodyear St. (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No) If yes, name country

3 (a) FULL NAME Baby Marsh.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-44

8. AGE: Years	Months	Days	If less than one day
Newborn		5 days	hr. min.

9. Birthplace Baltimore md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name William Marsh
13. Birthplace Lumberton N.C.

MOTHER
14. Maiden Name Ruth Gracy
15. Birthplace Balto. md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address FEB 15 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 8 - 1944, at 12 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1944, to 2-8-1944, and that I last saw him alive on 2-7-1944.

Immediate cause of death — Duration

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Butler M. D.
Address Garlett Hospital Date signed 2-8-44

VS 180

0726

G 24074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G 24074

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 943 N. Mount St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Edward Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) (Single) married, widowed, or divorced.
male	negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-14-44

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

MOTHER / FATHER

12. Name James Williams

13. Birthplace Nash Co. N.C.

14. Maiden Name Sarah Arrent

15. Birthplace Nash. Co. N. C.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location JOHN HOPKINS MEDICAL SCHOOL FEB 15 1944

18 (a) Funeral director Commissioner of Health

(b) Address

FEB 15 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1944 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14 1944, to 1-23 1944 and that I last saw him alive on 1-23 1944.

Immediate cause of death

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. W.B. Butler Asst. Res. M. D.

Address 2033 Druid Hill Ave. Date signed 2/14/44

0725

G 14075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 14075
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Middle River Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto L Hadewig (HADEWIG.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4 - 1887

8. AGE: Years	Months	Days	If less than one day
56	11	9	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Dietrich Hadewig
13. Birthplace Germany

MOTHER
14. Maiden Name Charlotte —?
15. Birthplace Germany

16 (a) Informant Mrs John Sitaly
(b) Address 1919 E Federal St

17 (a) Burial (b) Date thereof 2-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E Monument

18 (a) Funeral director Wendell C Humphreys
(b) Address 1701 N Broadway

(a) FEB 15 1944 (b) [illegible] for Williams, M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13- 1944, at 9:05 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J Walsh M.D.
Medical Examiner.
Date signed 2-13-44

G 14076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G 14076
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 S. Brunswick St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Brunswick St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Louis P. Hargis

3 (b) If veteran, name war —

3 (c) Social Security Account No. 7-03-4226

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary Hargis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22-1876

8. AGE: Years 67 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name Louis Hargis
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Rudolph L. Hargis
(b) Address 927 Brunswick St

17 (a) Burial (Burial, cremation, or removal?) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director E. B. WIPPERT SON
(b) Address 850 W. Baltimore, Md.

19 (a) [illegible] (b) Huntington Williams M.D. (Signature of registrar)

FEB 15 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Feb 14 1944.
and that I last saw him alive on Feb 12 1944.

Immediate cause of death Pulmonary Edema
(a) Decubitus Ulcer

Due to —

Due to —

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Rudolph L. Hargis M. D.
Address 2157 Wilkens Ave Date signed 2/15/44

G 14077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 14077
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward Greene Str
(c) Hospital or institution:
University Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Woodlawn, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6th Legant Road
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Virginia Reublich

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Chas F. Reublich
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/4/1876

8. AGE: Years	Months	Days	If less than one day
67	4	10	hr. min.

9. Birthplace Howard County, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Theodore H. Russell
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Ellicott
15. Birthplace Maryland

16 (a) Informant Mrs. Anna Reublich
(b) Address Ruxton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Woodlawn, Md.

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 300 Eutaw Place

19 (a) — (b) Huntington Williams (Registrar) (Signature)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1944, at 8.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1944 to 2/14 1944 and that I last saw her alive on 2/14 1944.

Immediate cause of death	Coma	Duration
Due to	Acidosis	
Due to	Diabetes	
Other Conditions	Heart failure	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Charles A. Kemper M. D.
Address University Hospital Date signed 2/14

G 14078 G 14078

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 14

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard + Green Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Allegheny

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 168 East main St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME KATHERINE KELLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1941

8. AGE: Years	Months	Days	If less than one day
3			hr. min.

9. Birthplace Frostburg, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name John L. Kelly

13. Birthplace Maryland

MOTHER 14. Maiden Name Constance Flanagan

15. Birthplace Maryland

16 (a) Informant [illegible] (Uncle)

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 15 44 (month) (day) (year)

(c) Cemetery or crematory St Michaels

Location Frostburg Md

18 (a) Funeral director Durst Funeral Home

(b) Address Frostburg Md

19 (a) [illegible] (b) Huntington Williams M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1944, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1944 to Feb. 15 1944, and that I last saw h[illegible] alive on Feb. 15 1944.

Immediate cause of death	Duration
Internal hydrocephalus →	
cerebellar failure	
Due to tuberculous meningitis (?)	
pending autopsy findings	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation (1) 2-10-44 (2) 2-11-44

Major findings of operation: (1) Inflammation - caseous process. Debated entirely (2) TB meningitis

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. K. T[illegible]

Address Univ. Hosp. Balto. Date signed 2-15-44 M. D.

VS 8

THOMPSON

G 14079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

Registered No. G 14079

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd and Calvert St.

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 Days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1207 HULL STREET (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME HUGH MAHL

3 (b) If veteran, name war

3 (c) Social Security Account No. 285-01-9810

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of ~~husband or~~ wife Jessie V. Mahl

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) April 10th 1905

8. AGE: Years	Months	Days	If less than one day
38	9	10 765	hr. min.

9. Birthplace Davis, WEST VIRGINIA (Town, county, and state)

10. Usual Occupation WOOD WORKER

11. Industry or business Garrad Mfg. Co

FATHER

12. Name REESE MAHL

13. Birthplace WEST VIRGINIA

MOTHER

14. Maiden Name MOLLIE HARR

15. Birthplace WEST VIRGINIA

16 (a) Informant Reese Mahl

(b) Address 1207 Hull St.

17 (a) Burial, cremation, or removal (b) Date thereof 2/16/44 (month) (day) (year)

(c) ~~Cemetery or crematory~~ Columbiana

Location Ohio

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) FEB 16 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1944 at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from December 28 1943 to Feb. 15 1944, and that I last saw him alive on Feb. 15 1944.

Immediate cause of death Cardiac - Respiratory Failure — Duration

Due to Subacute Bacterial Endocarditis — 48 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George W. Thurgatwood Jr. M. D.

Address 332 E. University Pkwy Date signed 2/14/44

G 19080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

(7) Registered No. G 19080

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Harris

3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife Jabe Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
84 83			hr. min.

9. Birthplace Gloucester Co. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lomack
13. Birthplace Gloucester Co. Va.

MOTHER
14. Maiden Name Susan Curtis
15. Birthplace Gloucester Co. Va.

16 (a) Informant William E. Parker
(b) Address 1793 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16-44 (month) (day) (year)
(c) Cemetery or crematory Gloucester Co. Va.
Location

18 (a) Funeral director Wm Katie F Williams
(b) Address 922 N. Edmondson St.

19 (a) Date received Feb 16 1944 (b) Huntington Williams, M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1944 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16-44 to 2-11-44 and that I last saw he alive on 2-11-44

Immediate cause of death
(a) Pneumonia
Due to Hypostatic
Other Conditions

(Include pregnancy within three months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Duration 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury

23. Signature H H Bainstead M. D.
Address 524 N. Caroline St. Balto Md
2/17/44

14081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 14081 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 N. Central Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Daisy Mossell Gordon

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife Lloyd Carter Gordon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1880

8. AGE: Years	Months	Days	If less than one day
63	3	26	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business home

MOTHER / FATHER
12. Name Henry T. Folles
13. Birthplace Balto Md.
14. Maiden Name Annie Elliott
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Harriette Siemers
(b) Address 3173 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Wilkerson Cook Inc
(b) Address 1217 St. Paul St.

19 Filed FEB 16 1944 (Date rec'd by State Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1944, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1944 to Feb 14 1944, and that I last saw alive on Feb. 14 1944

Immediate cause of death myocardial insufficiency
General anesthesia
Due to carditis.
Due to
Other Conditions chronic emphysema, arteriosclerosis.
(Include pregnancy within 3 months of death)

Duration
10 days
4 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C. Sobiloff M.D.
Address 4474 Kenwood Ave Date signed 2/14/44 M. D.

14082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

✓ G 14082 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 Jefferson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) All 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charlotte Whitaker

3 (b) If veteran, name war —
3 (c) Social Security Account No. — —

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) '865

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Eastern Shore of Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Jonathan S. Whitaker
13. Birthplace Mass

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Eastern Shore of Md.

16 (a) Informant Eldred Whitaker
(b) Address 3110 Pelham Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Marys
Location Hampden

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 16 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1944, at 11:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 2/13/44

VS 151

G 14083

AB-86296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14083 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1812 E. Lombard St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Rosa Bell Akehurst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-14-1866

8. AGE: Years	Months	Days	If less than one day
78	-	30	hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Richard Henry Akehurst

13. Birthplace Md

MOTHER 14. Maiden Name Julia A. Kidd

15. Birthplace Md

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address RECORDS

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Olivet

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (Date received by Registrar) FEB 16 1944 (Registrar's signature) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1944, at 12 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1944 to 2-13 1944, and that I last saw her alive on 2-13 1944.

Immediate cause of death	Duration
Pyogenic both Legs	2 wks
Appendicitis C-U Disease	?
Due to Gen Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-4-44; 2-12-44

Major findings of operation: Gangrene Rt. - Lt leg

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Donald Bowles M. D.

Address Balto City Hosp Date signed 2-19-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14084
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 East st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
a State Md b County
c City or town Balto
(If outside city or town limits, write RURAL and give town)
d Street No. 323 East st.
(If rural give location)
e Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine M. Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Rutherford B. Freeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25 1918

8. AGE: Years 32 | Months 11 | Days 21 | If less than one day: hr min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework
11. Industry or business Self

FATHER
12. Name Charles Salaco
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Terranti
15. Birthplace Italy

16 (a) Informant Lucille M Salaco
(b) Address 323 East st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Grant Rd
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul st

(a) Date received by registrar FEB 17 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14th 1944, at 5:50 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943, to Feb 12 1944, and that I last saw her alive on Feb 12 1944.

Immediate cause of death Meningo-Encephalitis — Duration 18 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank V. Mariello M. D.
Address 333 S. Eastern., Date signed 2/14/44

FRANK V. MARIELLO

(over)

G 14085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No. G 14085

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4202 Groveland ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs. Margaret M. Merriken

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married,~~ widowed, or ~~divorced.~~ Widowed

6 (b) Name of husband ~~or wife~~ James R. Merriken

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1867

8. AGE: Years 76 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name Geo. Tarr

13. Birthplace Md.

MOTHER 14. Maiden Name Virginia Ward

15. Birthplace Md.

16 (a) Informant Mrs. J. C. Reimer

(b) Address 4202 Groveland Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1-17-44 (month) (day) (year)

(c) Cemetery or ~~crematory~~ New Cem Md.

Location

18 (a) Funeral director William Cook Inc.

(b) Address 1 E. Lexington St.

19 (a) D 16 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15- 1944, at 1:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1944, to 1-15 1944, and that I last saw ~~her~~ alive on 1-14 1944.

Immediate cause of death.

Due to Carcinomatosis of abdomen — Duration ...

Due to Malignant papillary cystadenoma of ovary — Duration 10 yrs

Other Conditions Hypertension C V Disease (Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Young Jr. M. D.

Address Md. Gen. Hosp. Date signed 1-15-44

VS 3

6-14086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6-14086

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 N. Ann Street
(c) Hospital or institution:

6-14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write R.F.D. and give name)
(d) Street No. 17 N. Ann Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles H. Asher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Sophie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. **AGE:** Years: 50 | Months | Days | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Dept Consultant

11. Industry or business

FATHER
12. Name: Morris M. Asher
13. Birthplace: Russia

MOTHER
14. Maiden Name: Dille F.
15. Birthplace: Russia

16 (a) Informant: Leatore Asher (Bro.)
(b) Address: 2462 Lakeview Avenue

17 (a) Burial, cremation, or removal: Burial (b) Date thereof: 2-17-44 (month) (day) (year)
(c) Cemetery or crematory: Brai Israel Cong.
Location: Northern Ave

18 (a) Funeral director: Jack Levin Inc
(b) Address: 1434 E. Baltimore St

FEB 1 1944
(Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 15, 1944 at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: D. L. Wollenmeber M.D.
Medical Examiner
Date signed 2-15-44

G 14087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14087

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address SINAI HOSPT.
(c) Hospital or institution: MONUMENT ST
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 WENTWORTH RD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia K. ROSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife MORTON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 48 Months Days If less than one day hr min

9. Birthplace BALTO. MD (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name ABRAHAM LEVINE
13. Birthplace RUSSIA

MOTHER
14. Maiden Name MOLLIE
15. Birthplace RUSSIA

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-16-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO + CONKLIN STS

18 (a) Funeral director Jack Levine Inc.
(b) Address 1439 E. Balto. St.

19 (a) (Date received by Registrar) FEB 17 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1944, at 11 05 PM

21. I certify that death occurred on the date above stated, that I attended deceased from [illegible] 1944 to Feb 14 1944, and that I last saw h[illegible] alive on Feb 14 1944

Immediate cause of death: destruction of vital medullary centers — Duration

Due to cerebral hemorrhage

Due to malignant hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)
(e) Means of injury

23. Signature Harold Pillon M.D.

Address Sinai Hosp. Date signed Feb 17 1944

G 14088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 14088

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) /

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1227 McCulloh St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Infant Simon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife .....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
		1		

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER 12. Name William Simon

13. Birthplace Md

MOTHER 14. Maiden Name Lena Williams

15. Birthplace Va.

16 (a) Informant William Simon

(b) Address 1227 McCulloh St.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory .....

Location JOHN HOPKINS MEDICAL SURGICAL FEB 15 1944

18 (a) Funeral director Commissioner of Health

(b) Address Huntington Williams M.D.

Filed FEB 10 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1944, at 6 02 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1944 to Feb 12 1944 and that I last saw him alive on Feb 12 1944.

Immediate cause of death	Duration
Prematurity (34 weeks)	
Due to	
Due to	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature H. L. Bonfield M. D.

Address Provident Hospital Date signed 2-11-44

VS 150

0730

G 14089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 154

G 14089

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Md.
(b) Street address .....
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 171 Huntington ave (If rural give location)
If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Robt E. Stidham

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife .....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years	Months	Days	If less than one day
			4 hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Robert Stidham
13. Birthplace Balto Md

MOTHER
14. Maiden Name Ruth Carigo
15. Birthplace Balto Md

16 (a) Informant Robert Stidham
(b) Address 2141 Huntington Ave

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory .....
Location JOHN HOPKINS 1 - 1944

18 (a) Funeral director .....
(b) Address .....

19 (Date rec'd by registrar) FEB 1 - 1944 Registrar for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12-1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12-1944, to 2-12-1944, and that I last saw h alive on 2-12 1944

Immediate cause of death Prematurity — Duration .....

Due to —

Due to .....

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature Louis Dolan M. D.
Address 926 Wilkens Ave Date signed 2/14/44

VS 8

0.29

G 14090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 14090
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 371 Mason Ct
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 271 Mason Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shulanka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. 10 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alphonse Shulanka
13. Birthplace Chicago Ill

MOTHER
14. Maiden Name Kathleen Martha Baker
15. Birthplace Kyles Ford Tenn

16 (a) Informant Alphonse Shulanka
(b) Address 271 Mason Ct

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SURGICAL FEB 1, 1944

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 1 - 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1944 at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1944 to 19 ; and that I last saw h[illegible] alive on 2/15 1944.

Immediate cause of death — Duration

Premature — 10 hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon M. D.
Address 129 S. Bway Date signed 2/15/44

0728

G 14091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G 14091

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Santoga Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 Mayfield Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward N. Midlam

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4 1944

8. AGE: Years	Months	Days	If less than one day
0	0	12	hr. min.

9. Birthplace Balto, Md (town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Edward Midlam
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Agnes Rhode
15. Birthplace Balto, Md

16 (a) Informant Mrs Edward Midlam
(b) Address 2318 Mayfield Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Baltimore Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Pulaski St.

FEB 16 1944 (Date received by registrar) Hunting for Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1944, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1944 to Feb 15, 1944, and that I last saw him alive on Feb. 14, 1944.

Immediate cause of death	Duration
Acute Resp. Failure	
Due to Cong. Heart Disease	
Due to Dehydration	
Other Conditions Cong. club hands & no food	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. Tunney M.D.
Address Mercy Hosp Date signed 2/15/44

G 14092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14092 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1639 Cliftview Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1639 Cliftview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry E Quarengesser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Sarah A Quarngesser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4 ~~1868~~ 1869

8. AGE: Years	Months	Days	If less than one day
75	1	6	hr. 9 min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business retired

FATHER
12. Name Louis Quarngesser
13. Birthplace Germany

MOTHER
14. Maiden Name Don't know
15. Birthplace

16 (a) Informant Jerome Quarngesser
(b) Address 1639 Cliftview Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Feb 16/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Men Park
Location Taylor Ave Balto Co

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2006 Orleans St

19 (a) FEB 16 1944 (Date rec'd by registrar) (b) Interment Williams, MD Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 19 9am at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1944 to Feb. 13 1944 and that I last saw him alive on Feb. 12, 1944

Immediate cause of death: Coronary occlusion — Duration: 2 days
Due to: Arteriosclerosis — 5 yrs.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert E Singewald M. D.
Address 1613 E. North Ave. Date signed

(over)

14093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. G 14093

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3131 Abell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3131 Abell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Amanda Cassell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife M E Cassell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1865

8. AGE: Years	Months	Days	If less than one day
79	21	2	hr. min.

9. Birthplace Calvert Co Md (Town, county, and state)
10. Usual Occupation
11. Industry or business At home

FATHER
12. Name — Dorsey
13. Birthplace Md

MOTHER
14. Maiden Name Dorsey Lenox
15. Birthplace Md

16 (a) Informant Miss Louise Cassell
(b) Address 3131 Abell Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Allegany Ave

19 (a) FEB 16 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1944, at 9 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1944 to 2/15 1944 and that I last saw h[illegible] alive on 2/15 1944.

Immediate cause of death

Due to Hypostatic pneumonia — Duration 6 days

Due to

Other Conditions Nephritis — 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Amelia E. Link M.D.
M.D.
Address 2211 E Lake Ave Date signed 2/15/44

G 14094

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 14094
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Brentwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Braxton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 20 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Braxton
13. Birthplace Va.

MOTHER
14. Maiden Name Estella Langley
15. Birthplace Md.

16 (a) Informant Estella Braxton
(b) Address 1712 Brentwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Hahn
(b) Address 9 E. Lanvale St.

19 (a) (Date received by Registrar) Huntington Williams M.D. Registrar

FEB 16 1944

VS 781

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1944, 11:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular, left

Due to Malnutrition.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenweber M.D.
Medical Examiner.
Date signed 2-15-44.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W

4095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 C

Registered No. G 34095

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale + Greene St
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Duncarb Va
(If outside city or town limits, write RURAL and give town)
(d) Street No. V (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wentell (~~Wentz~~) (Wescott)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 20 | Months | Days | If less than one day hr. min.

9. Birthplace Duncarb, Va. (Town, county, and state)

10. Usual Occupation Telephone repairman

11. Industry or business

FATHER
12. Name George Wentell
13. Birthplace

MOTHER
14. Maiden Name Nina Stearns
15. Birthplace

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)

(c) Cemetery or crematory
Location Spring Hill Va

18 (a) Funeral director Charles F Powell
(b) Address 2427 Huntington Ave Baltimore Md

FEB 16 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1944, at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1944 to Feb 15 1944, and that I last saw h. l. alive on Feb 15 1944.

Immediate cause of death Respiratory failure — Duration 3 hrs.

Due to Fecal carcinoma — Duration 1 wk.

Due to Carcinoma of rectum & generalized metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred J Nelson M. D.
Address University Hospital Date signed 2/16/44

Estimate

VS 3

6 14096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 6 14096

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3Mo 15 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Bon Secours Hosp. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. Mother Benedicta (McComiskey), ELIZABETH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race wh

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/79

8. AGE: Years 64 Months 1 Days 27 If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER 12. Name Not Available

FATHER 13. Birthplace " "

MOTHER 14. Maiden Name " "

MOTHER 15. Birthplace " "

16 (a) Informant Convent Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-44 (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Balto Md

18 (a) Funeral director George A Farley

(b) Address Fulton & Fayette

19 (c) FEB 16 1944 (Date rec'd by registrar) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15- 1944, at 3 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1943, to 2-15 1944, and that I last saw her alive on 2-15 1944.

Immediate cause of death: Chronic Congestive Heart Failure — Duration: 2 mo.

Due to: Adeno Carcinoma Descending Colon ?

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/22/43

Major findings of operation: Carcinoma descending Colon

of autopsy: None.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. J. Krieg MD 2-15-44

Address Bon Secours Hosp Date signed

VS 2

4097 [illegible]74955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45B

G 14097 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern St.

(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr-7mos-20 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1414 Eutaw Place
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Palm Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married (Stumpf)

6 (b) Name of husband or wife Elizabeth Kent (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14-1876

8. AGE: Years	Months	Days	If less than one day
68	-	1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Phillips
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace Baltimore-Md.

16 (a) Informant BALTIMORE CITY HOSPITALS RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16, 44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Belmont Ave & Fleming Blvd

18 (a) Funeral director Edgar T. Fleming
(b) Address 1416 Light St.

19 (a) FEB 16 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15 1944, at 10:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1942, to 2-15 1944, and that I last saw [illegible] alive on 2-15 1944.

Immediate cause of death

Carcinoma of Tongue — Duration 5 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Donald Bruce

Address Balt City Hosp Date signed 2-15-44 M. D.

G 14098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467 Registered No. G 14098

1. PLACE OF DEATH:
(a) [illegible] City, Maryland
(b) Usual address 2117 Denison St.
(c) Hospital or institution:
Crawford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

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2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Mondawmin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie May Chase

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Geo. A. Chase, Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1891

8. AGE: Years	Months	Days	If less than one day
52	8	0	hr. min

9. Birthplace Huntingtown, Calvert Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Samuel Fowler
13. Birthplace Smithville, Calvert Co., Md.

MOTHER
14. Maiden Name Mary A. Conner
15. Birthplace Mercersburg, Pa.

16 (a) Informant Miss Mary E. Fowler
(b) Address 3401 Mondawmin Ave.

17 (a) Burial (b) Date thereof 2/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 16 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1944, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Feb 13 1944, and that I last saw h[illegible] alive on Feb 12 1944.

Immediate cause of death Carcinoma of uterus — Duration about 8 yrs.

Due to

Due to

Other Conditions Metastasis to Abdominal viscera and liver — Duration about 18 mo.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hallie D. Hubbard M. D.
Address 222 Harrison Blvd Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14099 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 E 41st st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHRISTOPHER MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
--	--	m	w	Married

6 (b) Name of husband or wife Ella M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1872

8. AGE: Years	Months	Days	If less than one day
71	3	20	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Real estate
11. Industry or business

FATHER
12. Name Frederick Miller
13. Birthplace Phila., Pa.

MOTHER
14. Maiden Name Margaret Schaefer
15. Birthplace Germany

16 (a) Informant Mrs. Ella M. Miller
(b) Address 505 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 16 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1944, at 8:35 P.M.

21. I certify that I took charge of the remains described above, held an ~~inquest~~ Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wellenmeyer M.D. Attending Medical Examiner.
Date signed 2-17-1944

G 14100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G 14100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3036 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES EDWARD BRANNON

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Ella A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1857

8. AGE: Years	Months	Days	If less than one day
86	8	16	hr. min.

9. Birthplace Mt. Savage, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Iron Moulder

FATHER
12. Name John Brannon
13. Birthplace McKeesport, Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. C. E. Willoughby
(b) Address 25 Hillside Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 16 1944
(Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1944 to Feb 13 1944. and that I last saw h alive on Feb 11 1944.

Immediate cause of death hypostatic pneumonia
Due to arteriosclerotic type heart disease
Due to Generalized arteriosclerosis
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration: several years.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Winchil M. D.
Address 2901 Edmondson Ave Date signed Feb 16 1944

14101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 14101
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Light St. Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fawn Alberta Marlow

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John E. Marlow
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1904

8. AGE: Years	Months	Days	If less than one day
40	0	15	hr. min.

9. Birthplace Galena, Kansas.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business Own home

FATHER
12. Name Thomas C. Ayers
13. Birthplace Strausburg, Ohio.

MOTHER
14. Maiden Name Olivia Wood
15. Birthplace Lima, Ill.

16 (a) Informant John E. Marlow
(b) Address Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memo.
Location Glen Burnie, A.A. Co. Md.

18 (a) Funeral director Thomas W. Singleton
Address Glen Burnie, Md.

FEB 16 1944

19 (a) (Date rec'd by registrar) Planting or Mitchell Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1944, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1944, to Feb. 15 1944, and that I last saw her alive on Feb. 15, 1944.

Immediate cause of death Metastatic carcinoma — Duration

Due to Carcinoma of breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Jan 27, 1944
Major findings of operation: Same as above (Metastatic carcinoma)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul E. Zukato M.D.
Address 213 Light St. Date signed 2/14/44

VS 8

14102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 14102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5506 Groveland Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5506 Groveland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Charles T. Forsyth

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lucy Jeffries
6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Oct. 27, 1879

8. AGE: Years: 64 | Months: 3 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: C. D. Caulk & Co.

FATHER
12. Name: John F. Forsyth
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Mary Taliaferro
15. Birthplace: ?

16 (a) Informant: Mrs. Lucy J. Forsyth
(b) Address: 5506 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery: Lorraine
Location: Windsor Mill Road, Baltimore

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19 FEB 16 1944 (Date rec'd by registrar) Justin for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-1942 1944 to Feb 14 1944, and that I last saw him alive on Feb 14 1944.

Immediate cause of death: Coronary thrombosis — Duration: 1 hr.

Due to: ad. pneu[monia] arteriosclerosis and hypertension — 9

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to ~~external causes~~, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hallie S. Willett M. D.
Address 2220 Garrison Blvd. Date signed

G 14103

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 14103 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 E. Chase St.
(c) Hospital or institution: none (West Baltimore General) 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 E. Chase St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond S. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced. ~~divorced~~ Married
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1883

8. AGE: Years	Months	Days	If less than one day
60	6	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Attorney-at-law
11. Industry or business

FATHER
12. Name John F. Williams
13. Birthplace Anne Arundel County, Md.

MOTHER
14. Maiden Name Lucy J. Sanderson
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Roger B. Williams
(b) Address 3209 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) FEB 16 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to Feb 14 1944
and that I last saw h[illegible] alive on Feb 14 1944.

Immediate cause of death Myocardial Insufficiency —

Due to Chronic Myocarditis

Due to Ordinary Decalcification

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Conrad Sewell M. D.
Address 712 Park Ave. Date signed

(OVER)

G 14104 ✓ G 14104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Alex Hunter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. ..... min.

9. Birthplace Eppes Alabama
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Hunter
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Emila Hunter
(b) Address 703 S. Bruce St

17 (a) Burial (b) Date thereof 2/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore Md.

18 (a) Funeral director Chas Alexander
(b) Address 927 N. Mount St.

19 (a) FEB 16 1944 (b) Huntington Williams
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1944, at 3:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Aneurysm descending aorta, syphilitic.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 2-15-44.

VS 151

Please write plainly. Use ink. Do not use pencil. Fill in all spaces. Where information is not known, supply correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/ 93D

G 14105
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Carson St. (If rural give location)
(e) Citizen of foreign country? C (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Wiader

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr Wilder
(b) Address Winchester & Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 16 1944 (Date rec'd by registrar) (b) Washington, D.C. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1944, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed February 14, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G 14106 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1338 Stockton Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 Stockton Av (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Elizabeth Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
53 yrs.			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Agnes Brooks
(b) Address 1338 Stockton Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Presstman St

19 (a) FEB 16 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/44, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 19xx, to Feb 1x 19xx, and that I last saw h- alive on Feb 1x 19xx.

Immediate cause of death La Grippe — Duration Jan 27/44

Due to Bronchopneumonia — Jan 30/44

Due to Nephritis — Jan 30/44

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Williams Frey M. D.
Address 1928 Penna Av Date signed 2/16/44

(over)

G 14107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92B

G 14107 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1937 madison Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1937 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert W. Chapman

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/1/1900

8. AGE: Years 43 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Chapman

13. Birthplace md

MOTHER 14. Maiden Name Saya Robinson

15. Birthplace md

16 (a) Informant Alice Chapman

(b) Address 1937 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)

(c) Cemetery or crematory Port Depart

Location md

18 (a) Funeral director Geo. U. Kelson

(b) Address 1203 Pressman St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1944 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27 1943 to Feb 1944 and that I last saw h[illegible] alive on 19

Immediate cause of death

Mitral Insufficiency

Due to

Due to

Other Conditions Coronic Nbes

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
9
9

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. H. Hughes M. D.
Address 1423 Linden Ave Date signed

VS 3

14108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G 14108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Edmonson ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Johnson

3 (b) If veteran, name war ? | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Ruth Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Dynamiter
11. Industry or business Construction (Roads)

FATHER 12. Name Arturine Johnson
13. Birthplace Va.

MOTHER 14. Maiden Name Rosie Carter
15. Birthplace Va

16 (a) Informant Elnora Prather
(b) Address 209 N. Mount St

17 (a) Burial (b) Date thereof Feb 16 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 922 N. Schroeder St.

19 (a) (b) Registrar
(Date rec'd by local registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12- 1944, at 2 59 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1944, to 2-12 1944, and that I last saw h-m alive on 2-12- 1944.

Immediate cause of death [illegible]
Cardiac Failure — Duration
Due to Embolism
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. C. Robertson M. D.
Address University Hospital Date signed 2-12-44

C 14109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. C 14109

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1827 Vine St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1827 Vine St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Mary Griffin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1891

8. AGE: Years	Months	Days	If less than one day hr.	min.
52 yrs	6	21		

9. Birthplace N. C. (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Henry Griffin

13. Birthplace N.C.

MOTHER

14. Maiden Name Sarah Daniell

15. Birthplace N.C.

16 (a) Informant Mary Griffin

(b) Address 1827 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location

18 (a) Funeral director Miss Kate R. Williams

(b) Address 322 N. Schroeder St.

FEB 16 1944 Huntington Williams (Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1944 at 7.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 10 1944 and that I last saw h ime alive on Feb 9 1944.

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jas. D. Julian Jr.

Address 511 N. Schroeder St. Date signed 2/16/44

14110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 14110

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or Institution: Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1608 Edmondson Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert Hardy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Clara Hardy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1904

8. AGE: Years 39 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Charleston S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Nellie

15. Birthplace S.C.

16 (a) Informant Clara Hardy

(b) Address 1698 Edmondson ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mr Katie R. Williams

(b) Address 3229 N. Johnson St.

FEB 16 1944 (b) Huntington Williams Registrar

(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1944 at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1944 to Feb 13 1944 and that I last saw h/m alive on Feb 13 1944.

Immediate cause of death: Bronchopneumonia — Duration: Yrs. Mos. Wks. Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature G L Banfield M. D.

Address Provident Hospital Date signed 2/13/44

G 14111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No. G 14111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 E 21st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 E. 21st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry August Buechman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Sophia Scheumann (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Apr 10 1891

8. AGE: Years	Months	Days	If less than one day
52	10	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Restaurant Manager
11. Industry or business

FATHER
12. Name August Buechman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Burger
15. Birthplace Baltimore

16 (a) Informant Mrs Jno Buechman
(b) Address 719 E. 21st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1318 Light St.

19 FEB 16 1944 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14-44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6-43 19 , to 2-14-44 , and that I last saw h alive on 2-8-44 19 .

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Sarcoma Paget's disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry S. Gumbel M.D.
Address 2703 Edmondson Date signed 2-15-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14112 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 S. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? None (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES MARIAN PIERPONT (~~MARIAN FRANCES~~ Pierpont)

3 (b) If veteran, name war None

3 (c) Social Security Account No. ~~None~~ 218-09-3259

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary Pierpont

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About Sept 16-1862

8. AGE: Years ~~80~~ 81 | Months 4 | Days 29 | If less than one day hr min

About-

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Pierpont
13. Birthplace Md.

MOTHER
14. Maiden Name Naomi Welderman
15. Birthplace Ellicott City - Md.

16 (a) Informant Mrs. Wahrenberg (Niece)
(b) Address 3505 Devonshire Drive - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) Date received by registrar FEB 16 1944 (b) Registrar's signature Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1944 at 1:30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wollenweber M.D.
Medical Examiner.

Date signed 2-15-44

G 14113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14113 / 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 S Sharp Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 S Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elnora J White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife David White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/1904

8. AGE: Years	Months	Days	If less than one day: hr.	min.
40 39	11	24		

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Harris
13. Birthplace Va

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Va

16 (a) Informant David S White
(b) Address 916 S Sharp Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaac L Bowen Son
(b) Address 1058 W Mount Royal Ave Balto Md

19 (a) (Local registrar) (b) Huntington Williams M.D.

FEB 16 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1944, at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1944 to 2/14 1944, and that I last saw h[illegible] alive on 2/14 1944

Immediate cause of death Uremia
Nephrosclerosis
Hypertension
Neglected

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Frankenberg M. D.

Address 1111 Lee Date signed 2/16/44

G 14114

G 14114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 67 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S. Highland Av (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME JAMES A. HUGHES

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 22 - 1884

8. AGE: Years	Months	Days	If less than one day
59	2	24	hr. ..... min. .....

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business Retired

FATHER
12. Name Peter Hughes
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Mc Sinnis
15. Birthplace Balto. Md.

16 (a) Informant Annie Hughes
(b) Address 311 S Highland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Lotts
Location Old Frederick Rd.

18 (a) Funeral director John A. McGan
(b) Address 3000 E. Balto. St

19 (a) ..... (b) ..... (Registrar)

FEB 16 1944

VS 150

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15 1944, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1943, to 2-15 1944, and that I last saw h~~im~~ alive on 2-14 1944.

Immediate cause of death Acute myocardial failure — **Duration** .....

Due to Arteriosclerotic Heart Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Acute myocardial failure

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Wm. J. Annich M. D.

Address Sinai Hosp. Date signed 2-15-44

G 14115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14115 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Holbrook St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Brazil (Rosalie Marion Brazil)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10th, 1942

8. AGE: Years	Months	Days	If less than one day
2	I	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Albert Brazil
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Helen Murphy
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Helen Brazil (Mother)
(b) Address 1726 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Edmondson Avenue Baltimore, Md.

18 (a) Funeral director George C. Ruth, Inc.
(b) Address 1726 Harford Avenue

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

FEB 14 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1944, at 9:50 A M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed February 14 1944

G 14116

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 14116 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3621 Hickory Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Hickory Ave.,
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John W. Harris

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-0929-A

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary C. Harris

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Oct. 29 1875

8. AGE: Years 68 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name John Harris
13. Birthplace Maryland.

MOTHER
14. Maiden Name Eliza Hampshire
15. Birthplace Maryland

16 (a) Informant Mrs. Mary C. Harris
(b) Address 3621 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Pleasant
Location Zamber, Carroll Co. Md.

18 (a) Funeral director C. M. Watts
(b) Address Westminster, Md.

19 (a) FEB 16 1944 (b) Hunter's or Pulaski, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1944 10.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to Feb 14 1944 and that I last saw h[illegible] alive on Feb 14 19 44

Immediate cause of death MYOCARDITIS — Duration 3 yrs.
CHRONIC BRONHITIS — 5 yrs.
Due to ARTERIOSCLEROSIS
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 263 E. Pleasant St. Date signed 2/15/44 M.D.

VS 3

G 14117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14117 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 E 20th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 E 20th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur F. O'Neill

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
48	—	—	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business Post Office Clerk

FATHER
12. Name John O'Neill
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Flynn
15. Birthplace Ireland

16 (a) Informant Mrs Mc. E. Hellmann Wife
(b) Address 725 E 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location —

18 (a) Funeral director Mary Mc Wadsfield
(b) Address 501 E 42nd Sts

19 (a) (Date rec'd by registrar) (b) Registrar
FEB 16 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1944, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Feb 14 1944, and that I last saw h[illegible] alive on Feb. 12, 1944.

Immediate cause of death Congestive Heart Failure
Due to Hypertensive Cardio-Vascular-Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Glassman M. D.
Address 4037 Falls Rd. Date signed 2/15/44

G 14118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14118

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy A. Redifer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Geo. E. Redifer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1871

8. AGE: Years	Months	Days	If less than one day
72	2	28	hr. min.

9. Birthplace Emmitsburg Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Geo. A. Slate
13. Birthplace Emmitsburg Maryland

MOTHER
14. Maiden Name Katherine E. Britz
15. Birthplace Emmitsburg, Maryland

16 (a) Informant Roy F. Redifer
(b) Address 525 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore Maryland

18 (a) Funeral director Young Bros.
(b) Address 5305 Park Heights Ave

FEB 16 1944

(c) (Signature of Registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1944, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1943, to Feb 15 1944, and that I last saw h[er] alive on Feb 14 1944.

Immediate cause of death Myocarditis — Duration 3 Mo
Due to Senility
Due to arteriosclerosis
Other Conditions Dropsy — 3 Mo
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L. Wells M.D.
Address 5276 Park Ave Date signed Feb. 15, 44

G 14119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 119a

Registered No. G 14119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 N. Bullough St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lyman

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-44

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Helen Lyman
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 16 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 16 1944 Huntington Williams M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1944, at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1944 to 2-14 1944 and that I last saw h[illegible] alive on 2-14 1944

Immediate cause of death	Duration
Acidosis & Diarrhea	
Due to Prematurity	
Due to	
Other Conditions Dehydration	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Hal Ingram M. D.
Address Union Hospital Baltimore, Md. Date signed 2-15 1944

VS 3

0733

G 14120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157M

Registered No. G 14120

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Mt Royal Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Pace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/21/44

8. AGE: Years	Months	Days	If less than one day
		7	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name Ivy Sweitzer Pace

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 16 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) FEB 16 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28/44 1944, at 2.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death Chronic peritonitis — Duration
prenatal in origin

Due to

Due to

Other Conditions Congenital malformed penis & scrotum
(Include pregnancy within 3 months of death)

Date of operation 1/22/44

Major findings of operation

of autopsy: Chronic peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Lynn M. D.
Address Univ Hosp. Date signed 1/31/44

VS 150

10731

14121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 14121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St
(c) Hospital or institution Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Shields Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	X

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Bl	Baby

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-44

8. AGE: Years	Months	Days	If less than one day
0	0	11	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER 12. Name Frank Jones
13. Birthplace Freemon, Va.

MOTHER 14. Maiden Name Josephine Jones
15. Birthplace Freeman Va.

16 (a) Informant Frank Jones
(b) Address 919 Shields Pl.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 16 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 16 1944 (b) Registrar
(Date rec'd by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1944 at [illegible] M

21. I certify that death occurred on the date above stated: that I attended deceased from 2-1 1944 to 2-8 1944 and that I last saw her alive on 2-8 1944.

Immediate cause of death	Duration
Pulmonary edema	
Due to Congenital heart (?)	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Estate Lazarus M. D.
Address Univ. Hospital Date signed 2-8-44
0732 Baltimore, Md

14122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 14122
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARIUM RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Moore

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widow

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50 49			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Randolph Brown
(b) Address 1914 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wes. H. Keben
(b) Address 1303 Preastman St

19 (a) FEB 16 1944 (Date rec'd by registrar) (b) Registrar Huntington Willi M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944 to Feb 11 1944 and that I last saw h alive on Feb 11 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 8 days

Due to Essential Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. W. Bayfield M. D.
Address Provident Hosp Date signed 2/21/44

G 14123

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92c

G 14123
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 468 S. Bentalou St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 468 S. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand Walter Huber

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-07-9290

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hilda Huber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25-1897

8. AGE: Years	Months	Days	If less than one day
46	7	21	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business B. & O. R.R.

FATHER
12. Name John Henry Huber
13. Birthplace Switzerland

MOTHER
14. Maiden Name Marie L. Schmidt
15. Birthplace Germany

16 (a) Informant Hilda Huber
(b) Address 468 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19-1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Co. Md.

18 (a) Funeral director George L. Lapenta
(b) Address 2101 Frederick ave

19 (a) 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1944 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1943 to Feb 16 1944, and that I last saw him alive on Feb 13 1944.

Immediate cause of death Myocardial Degeneration & Renal Oedema — Duration 2 Months

Due to Rheumatic Endocarditis & Myocarditis & Decompensation — Jan 1943

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot W Johnson M. D.
Address 3432 Druid Park Date signed

G 14124

JL - 85830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14124

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1358 Towson St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Donker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1854

8. AGE: Years 90 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William

13. Birthplace Germany

MOTHER

14. Maiden Name Catherine Schmidt

15. Birthplace Germany

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17. 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 914 Greenmount Ave

19 (a) FEB 16 1944 (Date registered) Hunter for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1944 at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1944 to 2/14 1944. and that I last saw her alive on 2/14 1944.

Immediate cause of death Cardiac failure; prob. coronary occlus. (?)

Due to A. S. & K. D.

Due to

Other Conditions Asthenia; senility.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Seymour M. D.

Address ACH Date signed 2/15

G 14125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14125 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Litting

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Flanz
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Heilman
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) [illegible] Harrington Williams Mortician
(Date rec'd by Registrar) FEB 16 1944 Registrar

VS 110

MEDICAL CERTIFICATION 2.30 pm

20. DATE OF DEATH Feb 14 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to Feb 14 1944, and that I last saw her alive on Feb 14 1944.

Immediate cause of death	Duration
Edema Lungs	3 days
Due to Chronic Bronchitis	1 Month
Due to	
Other Conditions Chronic Myocarditis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1601 E North Ave Date signed Feb 15-44

G 14126

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G 14126 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4307 UNDERWOOD ROAD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 48

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 UNDERWOOD ROAD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARION STEVENSON BUCKLER
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	DIVORCED

6 (b) Name of husband or wife THOMAS H BUCKLER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 3RD 1879

8. AGE: Years	Months	Days	If less than one day
69	0	11	hr. min.

9. Birthplace NEW YORK City, N.Y.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name DAVID STEVENSON
13. Birthplace NEW YORK City

MOTHER
14. Maiden Name MARION S. STEVENSON
15. Birthplace CORNWALL-ON-HUDSON, N.Y.

16 (a) Informant PAUL S. PARSONS
(b) Address RIDERWOOD, Md.

17 (a) Burial (b) Date thereof Feb 17 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Thomas'
Location Garrison Forest Md.

18 (a) Funeral director Henry McDaniel & Son
(b) Address McCulloh & Orchard Sts

19 (a) Filed (Date received by registrar) (b)
FEB 16 1944
Registrar
Hunter, for Phillips, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1944, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1942 to Feb. 14 1944, and that I last saw h— alive on Feb. 14 1944.

Immediate cause of death Carcinoma of breast metastatic to chest (lung + mediastinum)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Breast removed Nov. 1927
Major findings of operation: Carcinoma of breast.
of autopsy: Not done

Duration 6+ years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —
23. Signature John Tilden Howard M. D.
Address 12 E. Eager St Date signed Feb. 16, 1944

G 14127

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 115c

G 14127 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 East Calvert St.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Perryville, Md. Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Elaine Hickman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F.
5. Color or race Wht
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 14, 1943.
8. AGE: Years | Months 8 | Days 2 | If less than one day hr. min.
9. Birthplace Perryville, Cecil Co, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lester Hickman
13. Birthplace Conowingo, Md.

MOTHER
14. Maiden Name Elsie Barrow
15. Birthplace Lancaster Co, Pa.

16 (a) Informant Lester Hickman
(b) Address Perryville Md R.F.D.

17 (a) Burial (b) Date thereof Feb. 18-44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oakwood
Location Conowingo Md
18 (a) Funeral director Lee A. Patterson Son
(b) Address Perryville, Md.

FEB 17 1944
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16- 1944, at 7.0 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944, to Feb 16 1944, and that I last saw her alive on Feb 16 1944.

Immediate cause of death Respiratory Failure — Duration 24 hr

Due to Influenza, Acute Pharyngitis — 24 hr

Due to other diseases —

Other Conditions Marasmus — 6 mos

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Adrenal hyperplasia, Universal Arteriosclerosis, Myocardial degeneration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hurl Powell Jr. M. D.
Address Union Mem Hospital Date signed 2/16/44

G 14128 448182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14128 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George's
(c) City or town Piscataway (If outside city or town limits write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Haynes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/4/33

8. AGE: Years 11 | Months 10 | Days - | 12 | If less than one day: hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wallace Haynes.
13. Birthplace Kentucky

MOTHER
14. Maiden Name Z. Blandford.
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Piscataway
Location Route 202 Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

FEB 14 1944 (Date rec'd by registrar) Huntington Williamsport Pa.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1944, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1944 to Feb 16 1944, and that I last saw him alive on Feb 16 1944.

Immediate cause of death: Cardiac failure, exhaustion — Duration

Due to: septicemia & pneumonia

Due to: bronchopneumonia abscess

Other Conditions: chronic nephritis

(Is the pregnancy within 3 months of death)

Date of operation 2/9/44

Major findings of operation: bronchopneumonia abscess

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaye M.D.
Address J.H.H. Date signed 2/16/44

G 14129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 14129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 N. Howard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N. Howard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Thomas Lawler

3 (b) If veteran, name war no
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13th 1879

8. AGE: Years 64 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Elmira N.Y. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Hotel Stanley

FATHER 12. Name Thomas A. Lawler
13. Birthplace Unknown

MOTHER 14. Maiden Name Hannah Comerford
15. Birthplace Unknown

16 (a) Informant Lillian Lawler
(b) Address 214 Fayette St. Cumberland Md

17 (a) Removal (burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory St. Peter & Paul Cemetery
Location Cumberland Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) FEB 17 1944 (b) Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1944, at 7:00 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions Rt. Direct Inguinal Hernia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.

Date signed 2/16/44.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 14130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 866 W. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Weaver

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mathew Weaver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22nd 1865

8. AGE: Years 78 | Months 10 | Days 23 | If less than one day hr. min. 24

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: John Weaver
13. Birthplace: York Pa

MOTHER
14. Maiden Name: Selina Weaver
15. Birthplace: Balto. Md.

16 (a) Informant: Margaret Katzenberger
(b) Address: 508 Parkston

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 127 St. Paul St

19 (a) Date received by registrar FEB 7 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6 1944, at 1.05 A M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions: Varicose Ulcer legs bilateral (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Hugh B. McNally M.D. Medical Examiner.
Date signed 2/8/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14131

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 Kentucky Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Kentucky Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PRESTON B. GOCHNAUER SR.

3 (b) If veteran, name war —

3 (c) Social Security Account No. ✓

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gertrude Gochnauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1888

8. AGE: Years 55 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business American Wiping Cloth Co

FATHER
12. Name Chas. W. Gochnauer
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Stonesifer
15. Birthplace Balto Md.

16 (a) Informant Preston Gochnauer
(b) Address 1817 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

(b) Signature of Registrar

FEB 17 1944

Date of death

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 19 44, at 5 30 M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 2-15-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

76a

G 14132 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard + Madison
(c) Hospital or institution: Md. Gen.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Gerndale (If outside city or town limits, write RURAL and give town)
(d) Street No. Annapolis Blvd. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Evelyn May Charpiat

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife: ~~~
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1942

8. AGE: Years	Months	Days	If less than one day
2	0	21	____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation ____
11. Industry or business ~~~

FATHER
12. Name Frederick C. Charpiat
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Lillian M Knight
15. Birthplace Balto. Md.

16 (a) Informant Fred C. Charpiat
(b) Address Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location ____ Md.

18 (a) Funeral director William Cook Inc
(b) Address 1207 St. Paul St

FEB 17 1944 (Stamped by registrar) (b) ____ Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1944 at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1944 to Feb 16 1944 and that I last saw h[illegible] alive on Feb 16 1944.

Immediate cause of death ____ **Duration**
Agranulocytosis
Due to ____
Due to ____
Other Conditions Hemangioma of skin
(Include pregnancy within 3 months of death)
Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature L. Herman Williams M. D.
Address Md. Gen. Hosp. Date signed Feb. 16, 1944

FURNISH WHATEVER FURTHER INFORMATION MAY BE REQUIRED OF RELATIVES SHOULD BE CAREFULLY OBTAINED. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14133
Registered No.

PLACE OF DEATH:
Baltimore City, Maryland
Street address 104 W. Univ. Parkway.
Hospital or institution:

Length of stay in hospital or inst. (yrs., mos., or days) 17
Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. Univ Parkway (If rural give location)
(e) If foreign born, how long in U. S. A.? years

FULL NAME Florence Colton Warfield

If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

Name of husband or wife Nicholas N Warfield
6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) Feb. 27, 1867

Age: Years	Months	Days	If less than one day
76	11	19	hr. min.

Birthplace Balto, Md. (Town, county, and state)
Usual Occupation At home.
Industry or business

Name John Colton
Birthplace md
Maiden Name unknown
Birthplace md

Informant Mrs. Chas Scott
Address Clarksville, Md

Burial (Burial, cremation, or removal) (b) Date thereof 2-18-44 (month) (day) (year)
Cemetery or crematory Lutheran
Location Clarksville Md.
Funeral director J.C. Nagy undertaker
Address Ellicott City Md

Filed (Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1944, at 7 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944, to Feb 16 1944, and that I last saw her alive on Feb 15 1944.

Immediate cause of death Bronchop-Pneumonia — Duration 2-7-44
Due to cardio-vascular renal — 2 yr.
Due to arterio sclerosis — 2 yr.
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis F Krauseneck, M. D.
Address 722 N. Kenwood Ave Date signed 2/17/44

VS 3

14134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1920

G 14134 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 N. Charles St. (If rural give location)
(e) Citizen of foreign country? C (Yes or No) If yes, name country

3 (a) FULL NAME: Laura Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: W/d.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 2-1912

8. AGE: Years: 91 | Months: 2 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Howard Co, Md. (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Frank Reynolds
13. Birthplace: Howard Co.

MOTHER
14. Maiden Name: Nessie Conway
15. Birthplace: Howard Co. Md

16 (a) Informant: Nessie Conway
(b) Address: 3202 N. Charles St

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-17-44 (month) (day) (year)
(c) Cemetery or crematory: West Lisbon
Location: Howard Co, Md

18 (a) Funeral director: Archibald C. Gaddis
(b) Address: 2101 McCulloh St.

19 (a) 17 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 19 44 at 7.55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 19 44 to Feb 14 1944, and that I last saw her alive on Feb. 14 19 44

Immediate cause of death
1- Aortitis
2- Mitral Insufficiency
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: G. H. Bangaie M. D.
Address: Provident Hospital Date signed 2-14-44

G 14135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14135
Registered No.

1190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30d
(e) Length of stay in Baltimore (yrs., mos., or days) 30d.

2. USUAL RESIDENCE OF DECEASED:
(a) Same 2nd (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2586 Druid Park Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Jordan

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-17-44

8. AGE: Years — Months — Days 30 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Paul Jordon
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Coker
15. Birthplace Germany

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-[illegible]-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore County Md.

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Baltimore St

19 (a) FEB 17 1944 (Date rec'd by registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16-44 19 , at 10:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1944, to 2-16- 1944, and that I last saw him alive on Feb 16 1944

Immediate cause of death Acidosis
Dehydration

Due to Infantile diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration
30d

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. V. Katsaros Jr. M. D.
Address Date signed 2-16-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 2

ORF

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 6 14136

6 14136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 S. Catherine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 S. Catherine St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Christian C. Orf

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Margaret E. Orf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 / 26 / 1876

8. AGE: Years	Months	Days	If less than one day
67	11	19	— hr. — min.

9. Birthplace Baltimore, Md (town, county, and state)
10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name August Orf
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Christian C. Orf
(b) Address 113 S. Catherine St

17 (a) Burial, cremation, or removal
(b) Date thereof 2 / 17 / 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md

18 (a) Funeral director F. A. Shippert Son
(b) Address Baltimore, Monroe St

19 FEB 17 1944 (Signature of local registrar) Hunter Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 / 14 / 1944, at 11:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1944 to 2/14 1944 and that I last saw h[illegible] alive on 2/14 1944

Immediate cause of death: Cardiac decompensation
Due to: Arteriosclerosis
Due to: Hypertension
Other Conditions:

Duration: 10 days

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Rahn M.D.
Address 2145 N Balto Date signed 2/16/44

G 14137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14137

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4010 Oakford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Oakford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth H. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Geo. W. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18th 1858

8. AGE: Years	Months	Days	If less than one day
85	4	28 27	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER 12. Name David H. Bodenstein

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary E. Jones

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary E. Oliver

(b) Address 4010 Oakford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 2 (day) 18 (year) 44

(c) Cemetery or crematory Loudon Park

Location Balto. Md.

18 (a) Funeral director Geo. Weber & Son

(b) Address 2503 Edmondson Ave

FEB 17 1944

(Date received by Registrar) (b) Hunter-Jos. Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15th 1944 at 12:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to Feb 15 1944 and that I last saw h[illegible] alive on Feb 15 1944.

Immediate cause of death	Duration
Carcinoma of Kidney	1 month
Due to	
Due to Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.

Address Date signed

G 14138

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 14138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 E. Monument St
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 E Monument (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Bouldin (nee Schofield)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-16-41
8. AGE: Years 2 | Months 1 | Days 29 | If less than one day hr min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Ellwood Schofield
13. Birthplace Md

MOTHER
14. Maiden Name Mildred Bouldin
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 19 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn A. Co
18 (a) Funeral director Mrs Ida Bailey
(b) Address 1721 Jefferson St
(c) Huntington Williams N.Y.

FEB 17 1944 (Registered by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1944 at 900 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1944 to Feb 15 1944, and that I last saw her alive on Feb 15 1944.

Immediate cause of death: Respiratory failure — Duration
Due to: cerebral edema
Due to: post encephalitis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Anatomical Diag. 2/16/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaye M.D.
Address [illegible] Date signed 2/16/44

14139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

G 14139
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~same~~ 3 3rd + Calvert
(c) Hospital or institution: union memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 Penhurst Ave City (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Reitz
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 30 1879

8. AGE: Years	Months	Days	If less than one day
64	6	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Herman J. Reitz
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Carr
15. Birthplace Maryland

16 (a) Informant Miss Isabelle V. Reitz
(b) Address 2210 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by registrar FEB 17 1944 (b) Registrar's signature Hunter for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1944, at 12 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1944 to Feb 16 1944 and that I last saw h er alive on Feb 16 1944

Immediate cause of death Cardio-respiratory failure — Duration 8 days

Due to Cerebral Vascular Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James N. McCook Jr. M. D.
Address Union Memorial Hospital Date signed 2-16-44

G 14140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 14140

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVE ATTACHED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4315 Springdale
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4315 Springdale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA WYLIE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1876

8. AGE: Years	Months	Days	If less than one day
68	1	9	hr. min

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James H. Wylie
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sarah Dennis
15. Birthplace Va.

16 (a) Informant Mr. S. G. Kilmer,
(b) Address 408 Balto. Life Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

FEB 17 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1944, at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to 2-15 1944
and that I last saw h[illegible] alive on 2-14 1944

Immediate cause of death
Cardio-Vascular-Renal
Due to Uremia

Due to

Other Conditions Bronchial Asthma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
15 yrs
9

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. O. Talmer Pearce M.D.
Address 701 Eutaw Pl. Date signed 2/16/44

G 14141

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92E

Registered No. G 14141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORY RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 W Hamburg St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 180 W. Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Osborne Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1892

8. AGE: Years	Months	Days	If less than one day
51	4	26	hr. min.

9. Birthplace Annapolis Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Lloyd Brown
13. Birthplace Md

MOTHER
14. Maiden Name Harriett Owens
15. Birthplace Md

16 (a) Informant Joseph H Brown
(b) Address 101 Calvert St (Annapolis)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location L. A. Co. Md

18 (a) Funeral director Isaac L Brown Jr
(b) Address 108 W Monument St

Date received FEB 17 1944 (b) Registrar for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 — 13 — 1944 at 1120 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 — 5 — 1944 to 2 — 13 — 1944, and that I last saw him alive on 2 - 12 - 1944.

Immediate cause of death Acute Indigestion — Duration

Due to

Due to

Other Conditions Endocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Carper M. D.
Address 1016 E. Fleet St Date signed 2-17-44

G 14142 Rhoulace

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 E

Registered No. G 14142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2285 Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2285 Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Rhoulace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22 1873

8. AGE: Years	Months	Days	If less than one day
10	4	23	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lucus Collin
13. Birthplace N.C.

MOTHER 14. Maiden Name Ella Smith
15. Birthplace N.C.

16 (a) Informant Malinda W Brown
(b) Address 2285 Fremont Ave

17 (a) Burial (b) Date thereof 2/19/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaiah D Brown Son
(b) Address 850 Montgomery St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 17 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 15, 1944 at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 13 1944 to Feby 15 1944, and that I last saw h alive on Feby 13, 1944.

Immediate cause of death Cerebral Hemorrhage — Duration Some months

Due to Endocarditis

Due to

Other Conditions Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Victor Smith M. D.

Address 844 N. Carey St Date signed 2/17/44.

G 14143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13B

TN. 85681

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1504 E. Monument St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Leonaro Waters

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd, 1916

8. AGE: Years	Months	Days	If less than one day
27	2	13	hr min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Lenny Kelley

13. Birthplace Va.

MOTHER

14. Maiden Name Emma Whitlock

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Ox. Co. Md

18 (a) Funeral director H. Hertz Williams

(b) Address 15 15 E Mt[illegible]

19 (a) [illegible] (Date rec'd by Registrar) FEB 1 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1943, to 2/15 1944, and that I last saw h[illegible] alive on 12/14 1944.

Immediate cause of death Pulmonary T.B.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Jackson M.D.

Address Balto. City Hosp. Date signed 2/16/44

G 14144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14144 Registered No.

1218

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Light St.
(c) Hospital or institution: Jewish Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1950 Chesapeake Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. WHITWORTH Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-16-1036
4. Sex wh
5. Color or race col.
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Suberthia
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/28/93
8. AGE: Years 50 Months 9 Days 18 If less than one day hr. min.
9. Birthplace Bess City N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Geo W Whitworth Sr
13. Birthplace N.C.

MOTHER
14. Maiden Name Elizabeth Webber
15. Birthplace N.C.

16 (a) Informant Suberthia Whitworth
(b) Address 1950 Chesapeake's Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Bess City N.C.
18 (a) Funeral director Robt E Williams
(b) Address 45 16 McElderry St
19 (a) FEB 17 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16-1944 at 11:15 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 2-14-1944 to 2-16-1944 and that I last saw him alive on 2-16-1944.

Immediate cause of death: Ch. pleuro-pneumonia — Duration: 6 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Paul A. Lukato M. D.
Address 1213 Light St Date signed 2/16/44

VS 150

14145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14145 / 1496 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Fenelon Ave
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Poplar Grove St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs. Lois Maxine Kerr 21870

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Edward Lloyd Kerr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1922

8. AGE: Years	Months	Days	If less than one day: hr.	min.
21	5	26		

9. Birthplace Waynesboro Pa. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Allen Noel
13. Birthplace Waynesboro Pa., Md

MOTHER
14. Maiden Name Esther Richardson
15. Birthplace Virginia

16 (a) Informant Mr. Edward Lloyd Kerr
(b) Address Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19 1944 (month) (day) (year)
(c) Cemetery or crematory Green Hill
Location Waynesboro Pa.

18 (a) Funeral director Walter L. Grove
(b) Address Waynesboro Pa.

FEB 17 1944 (Date rec'd by Registrar) Hattie Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 1944 at 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1944 to 2-17 1944 and that I last saw him alive on 2-17 1944.

Immediate cause of death Acute respiratory failure

Due to Cause Undetermined

Due to

Other Conditions Full term pregnancy - 2nd Stage Labor

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D'Orazio Jr. M. D.
Address Md. Gen. Hosp. Date signed 2-17-44

VS 8

G 14146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

G 14146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st Street
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Oct. 19, 1943
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 515 N. Rose Street, Balto., Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Rose Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME RAY ASHER

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No. 411-12-1378

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Separated

6 (b) Name of husband or wife: Mary Ellen McCroy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1897

8. AGE: Years	Months	Days	If less than one day
47	0	22	hr. min.

9. Birthplace Salt Lake City, Utah (Town, county, and state)
10. Usual Occupation Steamfitter 6/2/43
11. Industry or business -

FATHER
12. Name George L. Asher
13. Birthplace Mo.

MOTHER
14. Maiden Name Nellie May Quick
15. Birthplace Ill.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) B (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Lake
Location Salt City - Utah

18 (a) Funeral director A. Lee Oden
(b) Address 4644 York Road

19 FEB 17 1944 (Date received by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Feb. 15, 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19, 1943 to Feb. 15, 1944, and that I last saw him alive on Feb. 15, 1944.

Immediate cause of death: Fracture of 11th Dorsal Vertebrae with compression of the spinal cord; — Duration: Aug. 10, 1943

Due to

Due to

Other Conditions: Kidney stones, rt; empyema, rt. chest; Decubital ulcers — Unk.
(Include pregnancy within 3 months of death)

Date of operation None done

Major findings of operation:

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 3/1
(a) Accident, suicide, or homicide Yes
(b) Date of occurrence Aug. 10, 1943 ?? at M According to City Hosp. records
(c) Where did injury occur? 1456 Eastern Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? Yes Estimating on building repairs
(e) Means of injury Fell down stairs from 2nd floor to 1st. Landing on back.

23. Signature J.S.Archer
Address Baltimore, Md. Date signed 2/16/44

For O.W.L. Mellenbruch, by Va-13868 Howard L. Mallett, M.D.

G 14147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9/a

G 14147 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Jan. 11, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 S. Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH KASINECK

3 (b) If veteran, name war	3 (c) Social Security Account No.
World's War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	-

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1896

8. AGE: Years	Months	Days	If less than one day
47	7	1	hr. min.

9. Birthplace Brest, Litvosk - Poland (Town, county, and state)
10. Usual Occupation Seaman - 9/43
11. Industry or business Merchant Seaman

FATHER
12. Name Philip Kasineck
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Fredk Ave
18 (a) Funeral director G. Lee Oder
(b) Address 4644 York Road.
(c) Huntington Williams

FEB 17 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Feb. 15, 1944 at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11, 1944 to Feb. 15, 1944 and that I last saw him alive on Feb. 15, 1944

Immediate cause of death Acute vegetative endocarditis with purulent thrombi in brain, spleen and right kidney — Duration Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/18/44-Incision rt. thigh & drainage
Major findings of operation: 1 cup pus removed.
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify Home, Farm, Industrial place, Public place)
(e) Means of injury

23. Signature J.C. Archer
Address Baltimore, Md. Date signed 2/ /44 M. D.

VS 180

Va-14236

G 14148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 14148 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Admitted: 2/4/44
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 N. Gay Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR WILLIAM MORGAN

3 (b) If veteran, name war: Sp.American
3 (c) Social Security Account No. 229-16-4827

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lola Dodson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.20, 1883

8. AGE: Years 60 | Months 4 | Days 25 24 | If less than one day: hr min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Counterman in restaurant
11. Industry or business -

FATHER
12. Name James Morgan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Baggett
15. Birthplace Washington, D. C.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 2-18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington Virginia

18 (a) Funeral director G. Lee Odle
(b) Address 4644 York Road.

19 (a) FEB 17 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1944 at 8:40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4, 1944 to Feb. 14, 1944, and that I last saw him alive on Feb. 14, 1944.

Immediate cause of death Pneumonia, Friedlander's, with acute lung abscesses, right upper lobe — Duration: Unk.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Cauchon M. D.
Address Baltimore, Md. Date signed 2/14/44

VS 180

Va-14286

14149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 820

G 14149 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 Union Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wallace Clark Seville

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1888

8. Age	Years	Months	Days	If less than one day
about	55			hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant "
(b) Address "

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory National National
Location Frederick Rd.

18 (a) Funeral director A. Lee Alder
(b) Address 4644 York Rd.

19 (a) FEB 17 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1944, at 7:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhage of brain

Due to

Other Conditions Marked pulmonary emphysema Cardiac hypertrophy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed January 30, 1944

G 14150

T.N 86465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 14150

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 75yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME
Theadore Diersore

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1868.

8. AGE: Years: about 75 | Months | Days | If less than one day: hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Unknown
13. Birthplace ? " "

MOTHER
14. Maiden Name ? " "
15. Birthplace ? " "

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Frederick Road

18 (a) Funeral director C. Vernon Leonard
(b) Address 4611 Park Heights Ave

19 (a) FEB 17 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1944 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1944 to 2-15 1944
and that I last saw him alive on 2-15 1944.

Immediate cause of death Diabetic coma; gangrene of foot;

Due to Diabetes mellitus

Due to arteriosclerosis

Other Conditions Dehydration; (Include pregnancy within 3 months of death)
Acid. emphysema

Date of operation

Major findings of operation:

of autopsy: No post

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergeon M. D.

Address DCH Date signed 2/17

Morgue

14151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30 D

Registered No. 14151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 4 D
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 Bloom Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Edward Bowen

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	W

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/23/1890

8. AGE: Years	Months	Days	If less than one day
53	11	22	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Elevator operator
11. Industry or business

FATHER 12. Name	Geo. H. Bowen
13. Birthplace	Birch Hill, Md
MOTHER 14. Maiden Name	F. Pitkin
15. Birthplace	New Windsor, Md

16 (a) Informant Naomi Lyres
(b) Address 532 Bloom St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelzon
(b) Address 1303 Presstman

19 (a) FEB 17 1944 (Date rec'd by Registrar) (b) Interment [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1944, at 4:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy and dilatation

Due to Syphilitic aortitis and Valvulitis

Other Conditions

(include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Roland Ruggeri M.D. Medical Examiner.
Date signed Feb. 16 1944

G 14152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 14152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 N. Stricker Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 907 N. Stricker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-1899

8. AGE: Years	Months	Days	If less than one day
44 43	1	15	hr. min.

9. Birthplace Prospect, Va.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Fairfield Shipyards

FATHER
12. Name Paul Scott
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Rose Scott
(b) Address 907 N. Stricker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Mrs. Lizzie V. Holland
(b) Address 631 Druid Hill Ave.

19 (a) [illegible] (b) [illegible]
Registrar

FEB 17 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1944, at 10:40 P.M.

21. I certify that I took charge of the remains described above, held an inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 6 14153

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2431 Jefferson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Cunningham

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
---	none	Male	White	Married

6 (b) Name of husband or wife Katie Cunningham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1882

8. AGE: Years	Months	Days	If less than one day
61	11	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Engineer, Balto. City School
11. Industry or business

FATHER
12. Name James Cunningham
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rosetta Turner
15. Birthplace Balto. Md.

16 (a) Informant Katie Cunningham
(b) Address 2431 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19/44 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) Date received by Registrar FEB 17 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16/44 19 , at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1941 to Feb 16 1944, and that I last saw him alive on Feb. 14 1944.

Immediate cause of death Coronary Occlusion — Duration 3 hours
Due to Hypertensive C-V-R — 10 yrs.
Due to Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2413 E Monument St. Date signed 2/17/44

G 14154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 14154 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Milton Ave (Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Loehning (LOETHING)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6/1885

8. AGE: Years 58 | Months 6 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name George H Moore
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Clotilda Jackson
15. Birthplace Germany

16 (a) Informant Rt.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Philip Henri Storm
(b) Address 2024 Calvert St

FEB 17 1944 (Date rec'd by Registrar)

(b) Hamilton for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1944, at 10½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1944, to Feb 16 1944, and that I last saw her alive on Feb 16 1944.

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to Pneumonia and uremia	4 days
Due to Diabetic arteriosclerosis	10 yrs
Other Conditions Gangrene foot - left	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. Smythe M.D.
Address Mercy Hospital Date signed 2/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(C) 14155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. 14155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 S. CONKLING ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 S. CONKLING ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS M. SULLIVAN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife GEORGANNA SULLIVAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 10 1873

8. AGE: Years 70 | Months 4 3 | Days 4 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation IORN MOULDER
11. Industry or business

FATHER
12. Name JERMAN SULLIVAN
13. Birthplace IRELAND

MOTHER
14. Maiden Name DELLA JOYCE
15. Birthplace IRELAND

16 (a) Informant JOHN C. SULLIVAN (SON)
(b) Address 809 S. CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 18/44 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD

18 (a) Funeral director Lilly and Zeiler INC
(b) Address 1403 S. WOLFE ST.

19 (a) FEB 17 1944 (Date rec'd by registrar) (b) Hampton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH FEB. 14 1944 at 7/45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/44 19 , to 2/14 1944.
and that I last saw h alive on 2/11/44 19 .

Immediate cause of death: Acute Cardiac dilatation — Duration:
Due to Myocarditis Chronic and Chronic nephritis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. McGarrell
Address 803-5-Conkling Date signed 2/15/44 M. D.

J. J. McGARRELL

14156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G 14156

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1842 N. Wolfe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1842 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine L. Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Charles A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1887

8. AGE: Years	Months	Days	If less than one day
56	1	19	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Segrist
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Schuman
15. Birthplace Baltimore Md.

16 (a) Informant Charles A. Green
(b) Address 1842 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 Filed FEB 17 1944 (b) [illegible] for Williamson
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1944, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 9, 1943, to Feb. 14, 1944, and that I last saw h[illegible] alive on Feb. 14, 1944.

Immediate cause of death Adeno Carcinoma of Uterus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weiss, M.D.
Address 1927 E. North Ave. Date signed 4/16/44

G 14157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Cold Spring Lane
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3427 Elliott St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Lemuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 8, 1862

8. AGE: Years 81 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William Brill

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Frank

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. Mary Gluth

(b) Address 3427 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)

(c) Cemetery or crematory Schwartzs

Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

19 (a) FEB 17 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1944, at 9:30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1943, to Feb 14 1944, and that I last saw her alive on Feb 14 1944.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. Culbertson M. D.

Address 2324 Reisterstown Rd Date signed 2/16/44

G 14158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14158 Registered No. 91a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 ~~7~~ 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 N Patterson Pk (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William C. Viewig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ida M Viewig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 4-4-1887

8. AGE: Years 56 | Months 9 | Days 13 | If less than one day: hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation: Moving Business

11. Industry or business:

FATHER
12. Name: Charles H Viewig
13. Birthplace: Balto

MOTHER
14. Maiden Name: Katherine Lutz
15. Birthplace: Balto

16 (a) Informant: C R Hines
(b) Address: 2703 Bayonne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: City

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 8004 S. Wilkens

19 (a) FEB 17 1944 (Date first duly registered) (b) Harrington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1944, at 5:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1944 to Feb. 17 1944, and that I last saw him alive on Feb. 17 1944.

Immediate cause of death	Duration
Subacute bacterial endocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Thomas Brennan M. D.
Address: St Joseph's Hospital Date signed 2-17-44

14159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 14159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 Benning Lawn Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 18
(e) Length of stay in Baltimore (yrs., mos., or days) 0045

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Benning Lawn Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME Martha Redmer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Albert E Redmer

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Dec 1867

8. AGE: Years 76 | Months 2 | Days | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state or country)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name Frank Klein Inman
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Knoll
15. Birthplace Germany

16 (a) Informant Mr Hugo Redmer
(b) Address 2321 E Madison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2207 E Oliver St

19 (a) FEB 17 1944 (Registrar's signature) Huntington Williams M.D.
VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/44 19 45 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1944 to Feb 14 1944 and that I last saw her alive on Feb 14 1944

Immediate cause of death: Bronchopneumonia — Duration: 4 days

Due to:

Due to:

Other Conditions: Fracture R. femur. Hypoglycemia (terminal) — 19 days

(Include pregnancy within 3 months of death)

Date of operation Jan 29 1944

Major findings of operation: Reduction fracture and pinning R. femur neck

of autopsy: Non

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide or homicide~~ Fractured femur R.
(b) Date of occurrence January 25 1944. M
(c) Where did injury occur? Baltimore (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Simple fall off bed.

23. Signature H. H. Chaffee M.D.

Address 6710 York Road Date signed 2/16/44

For S.H.D. Mortenson by Howard J. Chaffee, M.D.

G 14160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G 14160 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 S Robinson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S Robenson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Maaser

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 1878

8. AGE: Years 65 66 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Retired

FATHER
12. Name Geo Maaser
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Anna Maaser
(b) Address 414 S Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Rural

18 (a) Funeral director Welsh Funeral Home
(b) Address 200 E. Oliver

FEB 17 1944 (Date received by registrar) Huntington Williams, M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1944 at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1943 to Feb 17 1944 and that I last saw h[illegible] alive on Feb 17 1944.

Immediate cause of death: Mitral Insufficiency — Duration 1 yr.
Due to: Arterio sclerosis — Duration ?
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. H. L. Hohenstein M.D.
Address 752 N. Broadway Date signed 2/17/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 c

G 14161 ✓ G 14161 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 Kingsley St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Carol Jean Cooper

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1942

8. AGE: Years 1 | Months 3 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name John Baker Cooper
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Lucile Eitze
15. Birthplace Baltimore

16 (a) Informant J. B. Cooper
(b) Address 3220 Kingsley St. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20 1944 (month) (day) (year)

(c) Cemetery or crematory Poplar
Location Cockeysville, Md

18 (a) Funeral director Landon M. Bowles
(b) Address Sparks

FEB 17 1944 (Date accepted for registration) Washington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1944 at 12 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1944 to 2/17 1944 and that I last saw h-r alive on 2/17 1944.

Immediate cause of death: Acute laryngo-tracheo-bronchitis — Duration: 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Tracheotomy 2/16/44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund Rogen, M. D.
Address Bon Secours Hosp. Date signed 2/17/44

G 14162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G 14162 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121½ McCulloh
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121½ McCulloh
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Juliet B Houston

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: James E. Houston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900
8. AGE: Years 44 | Months | Days | If less than one day: hr. min.
9. Birthplace Washington D.C
(Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John H. Bunday
13. Birthplace D.C.

MOTHER
14. Maiden Name Phyllis Jackson
15. Birthplace Va

16 (a) Informant Edna Hendricks
(b) Address 2121½ McCulloh St

17 (a) Burial (b) Date thereof 2/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Harmony D.C
Location

18 (a) Funeral director James A Hayes
(b) Address 1142 W Fayette St

FEB 17 1944 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 — 1944, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1944 to 2/15 — 1944, and that I last saw her alive on 2/15 — 1944

Immediate cause of death: Carcinoma
Due to: cervix & Liver
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burkett M. D.
Address 2/3 [illegible] Date signed

G 14163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 14163 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6534 Rosemont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6534 Rosemont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick W. Schilling

3 (b) If veteran, name war	3 (c) Social Security Account No.
no.	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widower

6 (b) Name of husband or wife Mary P. Schilling
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 17, 1870

8. AGE: Years	Months	Days	If less than one day
73	8	30	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Frederick Schilling
13. Birthplace Md.

MOTHER
14. Maiden Name [illegible] Krouse
15. Birthplace [illegible] - Md.

16 (a) Informant John L. Burka
(b) Address 6534 Rosemont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Vernon Kohler
(b) Address 2301 Edmondson Ave

(c) Date received by Registrar FEB 17 1944 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1944 3:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1943 to Feb. 16 1944, and that I last saw him alive on Feb. 16 1944

Immediate cause of death Chronic myocarditis — Duration 1 yr

Due to Arteriosclerotic cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Wolfe M.D.
Address 1221 E. Lafayette Ave Date signed 2-16-44

274966 14164 BALTIMORE CITY HEALTH DEPARTMENT G 14164
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 W Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susie Braxton
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: female
5. Color or race: black
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife: Joseph Braxton
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-14-1891
8. AGE: Years 53 | Months - | Days 29 | If less than one day hr min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Phillip Carter
13. Birthplace
MOTHER 14. Maiden Name Margaret Williams
15. Birthplace
16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-44 (Month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Sam'l H. Chase & Son
18 (a) Funeral director Sam'l H. Chase & Son
(b) Address 638 N. Eutaw St
19 (a) FEB 17 1944 (Date received by registrar) (b) Registrar
VS 150

MEDICAL CERTIFICATION
20. DATE OF DEATH Feb 13 1944 at 4:37 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1944 to 2/13 1944, and that I last saw her alive on 2/13 1944.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Pulmonary edema	5 hrs.
Due to: Hypertensive cardiovascular disease	yrs.
Other Conditions: Obesity, Pneumonia - Rt L, R m L. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Graham Loomis M. D.
Address J Hopkins Date signed 2-13-44

G 14165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G 14165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton Robinson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	1	7	hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

JOHN HOPKINS MEDICAL SCHOOL FEB 1 - 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) FEB 17 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4 1944, at 10:50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Enterocolitis

Due to

Other Conditions Nutritional Disturbance

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 2-5-44

0738

Correct entries are necessary for statistical purposes. Blanks left on account of information unobtainable or carelessly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

G 14166

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga St.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 10

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 867 Greenmount ave. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Augustus Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 2, 1870

8. AGE: Years	Months	Days	If less than one day
73 72	11	13 11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Dennis Scott

13. Birthplace Maryland

MOTHER — 14. Maiden Name .....

15. Birthplace Maryland

16 (a) Informant Jane Sproot

(b) Address 842 Greenmount ave.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory .....

Location JOHN HOPKINS MEDICAL SCHOOL FEB 17 1944

18 (a) Funeral director ..... Commissioner of Health

(b) Address .....

19 (a) FEB 17 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

0.132

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1944 at 10 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1944 to Feb 13 1944 and that I last saw h[illegible] alive on Feb 13 1944.

Immediate cause of death Ruptured Ectopic Pregnancy

Due to Laceration of Liver

Due to .....

Other Conditions Primary source probably Renal (Include pregnancy within 3 months of death)

Date of operation 2/11/44

Major findings of operation: Carcinoma of kidneys, spleen, liver

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Paul P. Ziegler

Address 521 Mt. Holly St Date signed 2/13/44 M. D.

G 14167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G 14167 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 Lancaster St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Lancaster St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Ermantowski (ERMATOWSKA)

3 (b) If veteran, name war No

3 (c) Social Security Account No. 214-18-3213

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John Ermatowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
30	—	—	hr. min

9. Birthplace New Portsmouth Va. (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name John Kroll
13. Birthplace Poland

MOTHER
14. Maiden Name Zofia Skowronska
15. Birthplace Poland

16 (a) Informant John Ermatowski
(b) Address 1716 Lancaster St

17 (a) Buried (Burial, cremation, or removal) **(b) Date thereof** 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozaguski
(b) Address 1930 Eastern Ave

19 (a) FEB 17 1944 (Entered by registrar) **(b)** (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1944 to 2/16 1944 and that I last saw h alive on 19

Immediate cause of death Cardiac dilatation
Due to auricular fibrillation
Due to C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

Duration
4 mts.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Max Murphy M. D.
Address 7046 Chase Date signed 2/16/44

Huntington Williams, M.D.

14168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14168
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 2722 Glendale Rd. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Dorothy Annette Powell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Child
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-1943

8. AGE: Years | Months: 4 | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Paul H. Powell
13. Birthplace Va.

MOTHER
14. Maiden Name Dorothy Edna Bonath
15. Birthplace Md.

16 (a) Informant Paul H. Powell
(b) Address 2722 Glendale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard F. Muth
(b) Address 5305 Harford Rd.

FEB 17 1944 Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1944 at 2.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1944 to Feb 16 1944, and that I last saw her alive on Feb 16 1944.

Immediate cause of death: Pulmonary edema Cardiac Failure — Duration: Seconds

Due to Pneumonia Staphylococcic — Duration: 7 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilat. Lobular, Consol.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary R. Shaeffer M.D.
Address Union Memorial Hosp. Date signed 2-16-44

14168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 14168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3103 Cheeley Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3103 Cheeley Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Amanda Milburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Dwayne Milburn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1867

8. AGE: Years	Months	Days	If less than one day
76	11	6	hr. min.

9. Birthplace Harford Co., Maryland (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Randolph Chirling

13. Birthplace Germany

MOTHER 14. Maiden Name Caroline ?

15. Birthplace Germany

16 (a) Informant Lillian M. Cox

(b) Address 3103 Cheeley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/44 (month) (day) (year)

(c) Cemetery or crematory Spetsuse

Location Perryman, Maryland

18 (a) Funeral director Conrad J. Ruck

(b) Address 5305 Harford Road

FEB 17 1944 (Date rec'd by Registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 17 1944 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6/44 19 to 2/17/44 19, and that I last saw her alive on 2/16/44 19

Immediate cause of death Cardiac failure — Duration

Due to Cardiac decompensation

Due to Arteriosclerotic cardiovascular renal disease

Other Conditions Hemiplegia; fibrillation

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Isadore Shorofsky M.D.

Address 6307 Harford Rd. Date signed 2/17/44 M.D.

Baltimore 14, Md.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 14170 Registered No.

CERTIFICATE OF DEATH 937

G 14170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1606 Division St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Division St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Della Moore

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife Willis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/5/1886

8. AGE: Years	Months	Days	If less than one day
57	10	9	hr. min.

9. Birthplace Williamson, N.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Housewife

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Pattie Bailey
15. Birthplace N.C.

16 (a) Informant James Moore (Son)
(b) Address 1606 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. County Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) Date received FEB 17 1944 (b) Registrar Huntington Williams M.D.

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/44 19 at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1943 to Feb. 13 1944 and that I last saw h[illegible] alive on Feb. 13, 1944.

Immediate cause of death Coronary sclerosis — Duration 7 days
Due to Myocardial Degeneration — 2 mos.
Due to Arterio-sclerosis (Renal)

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: (illegible)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. H. Pendleton M.D. M. D.
Address 1632 Druid Hill Ave Date signed 2-17-44

G 14171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

G 14171 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green + Redwood Sts
(c) Hospital or institution: Univ. Hospital 1656
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto. - (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 N. Augusta Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August Hugelheim

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Amelia Heim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1860

8. AGE: Years	Months	Days	If less than one day
83	9	4	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Machinist Retired
11. Industry or business

FATHER
12. Name Hugelheim
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Amelia Hugelheim
(b) Address 804 Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21, 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Harry W. Wotjze
(b) Address 1901 Edmondson Ave

19 (a) FEB 17 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17-44 19 , at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1944 to 2-17 1944, and that I last saw h/M alive on 2-11-1944.

Immediate cause of death	Duration
Heart Failure	
Due to Fat Embolism	
Due to	
Other Conditions Fractured Femur.	

(Include pregnancy within 3 months of death)
Date of operation 2-14-44
Major findings of operation: Fracture of neck of Femur.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence February 13, 1944 M
(c) Where did injury occur? At home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Fell from step

23. Signature J. J. Kenny M. D.
Address Date signed 2-17-44

VS 3

Approved: Robert E. Foster M.D. Asst. Med. Examiner 3/18/44

G 14172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14172 Registered No.

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
City or town Cambridge
(If outside city or town limits write RURAL and give town)
(d) Street No. 1327 Carmel Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver R. Harbin

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-12-1681

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Bertha Craft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1884

8. AGE: Years	Months	Days	If less than one day
59 62	4	-	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business B+O R.R.

FATHER
12. Name Harbin
13. Birthplace Ohio

MOTHER
14. Maiden Name Pringle
15. Birthplace Ohio

16 (a) Informant Carl R. Harbin
(b) Address Cambridge, Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21/44 (month) (day) (year)
(c) Cemetery or crematory Cambridge
Location Cambridge Ohio

18 (a) Funeral director Harry H. Fritzlee
(b) Address 401 Edmondson Ave

19 (a) 3-10-44 (Date received by registrar) (b) Hunter Williams, M.D. Registrar

DI 1441

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1944, at 10:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Ohio death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed February 17, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 14173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 1943
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lloyd L. Parker

3 (b) If veteran, name war

3 (c) Social Security Account No. 236-09-0670

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Alice Cheatham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26, 1910

8. AGE: Years	Months	Days	If less than one day
33	11	21	hr. min.

9. Birthplace W. Va (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Bethlehem Steel Co

FATHER
12. Name Wm B. Parker
13. Birthplace Va

MOTHER
14. Maiden Name Emma B. Rigney
15. Birthplace Va

16 (a) Informant Mrs. Alice Parker
(b) Address 119 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21/44 (month) (day) (year)
(c) Cemetery or crematory Stamford Cemetery
Location Stamford W. Va

18 (a) Funeral director Harry H. Twigg
(b) Address 401 Edmondson Ave

19 (a) FEB 17 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1944, at 7:25 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24-2
(a) Date of injury February 16, 1944
(b) Where did injury occur? Bethlehem Steel Co Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial place While at work? Yes
(d) Means of injury Fell 30 feet from staging

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed February 17, 1944

Huntington Registrar

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G 14174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G 14174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3219 Leeds Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 Leeds Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Sales

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 11 — 1874
8. AGE: Years 70 | Months — | Days 6 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Fireman Retired
11. Industry or business B & O. R.R.

FATHER
12. Name Charles T. Sales
13. Birthplace Md.

MOTHER
14. Maiden Name Almira V. Smith
15. Birthplace Md.

16 (a) Informant Anna E. Schumacher
(b) Address 321 S. Fremont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19-1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director George E. Schwab
(b) Address 2101 Frederick Ave

19 (a) FEB 17 1944 (Date filed by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1944 at 5 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1944 to Feb 17 1944 and that I last saw him alive on Feb 16 1944.

Immediate cause of death: Coronary Thrombosis — Duration 4 Days
Due to: Cardiac Vascular Hypertension & Degeneration — 5 Years
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson M. D.
Address 3432 Frederick Ave Date signed

G 14175 1-M 86466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 ✓ G 14175 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVE REGISTER FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Palewicz (Palowick)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Antoinette Palewicz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1886

8. AGE: Years	Months	Days	If less than one day
58	?	?	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Palewicz
13. Birthplace Germany

MOTHER
14. Maiden Name Betty ?
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart (Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) FEB 18 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1944, at 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1944, to 2/15 1944, and that I last saw him alive on 2/15 1944.

Immediate cause of death	Duration
Cardiac failure; asphyxia, coronary occlusion	2 mo.
Due to H.C.V.D.	
Due to	
Other Conditions Chron. bronchitis & asthma	

(include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M.D.
Address [illegible] Date signed 2/16

G 14176

Costello

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 14176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMAIN UNFOLDED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Costello

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas L

13. Birthplace

MOTHER 14. Maiden Name Catherine Mathews

15. Birthplace ?

16 (a) Informant Little Sisters of the Poor

(b) Address 1201 Valley Street

17 (a) Burial Cathedral Cem (Burial, cremation, or removal) (b) Date thereof Feb 18, 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem

Location Baltimore

18 (a) Funeral director Vida Wiedefeld

(b) Address 914 Fremont and Pace

19 (a) Filed FEB 19 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1944, at 1 P. m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-10 1944, to Feb 16 1944, and that I last saw her alive on Feb-16 1944

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall

Address 1631 North Ave Date signed 2/17/44 M. D.

DREWS ✓

G 14177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G 14177

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christian Drews

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Widowed

6 (b) Name of husband or wife Anna Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Denmark (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Peter
13. Birthplace Denmark

MOTHER
14. Maiden Name Louise Petersen
15. Birthplace Denmark

16 (a) Informant Little Sisters of the Poor
(b) Address 1201 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Weidefeld
(b) Address 914 Greenmount Ave

19 (a) Date received FEB 18 1944 (Local registrar) Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION 5 p.m.

20. DATE OF DEATH Feb. 16 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1944, to Feb 16 1944, and that I last saw him alive on Feb 16 1944.

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic myocarditis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall
Address 1631 2 North Ave Date signed 2/17/44 M. D.

G 14178 #49509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104 B

G 14178 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town La Platta (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Maddox

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-28

8. AGE: Years 16 | Months 0 | Days 12 | If less than one day: hr. min.

9. Birthplace D.C. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name John Maddox
13. Birthplace Md.

MOTHER
14. Maiden Name Anne Willis
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-44 (month) (day) (year)
(c) Cemetery or crematory
Location Waldorf Md

18 (a) Funeral director Humbert + Ryon
(b) Address Waldorf Md

19 (a) FEB 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1944 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1944 to Feb 17 1944 and that I last saw h[illegible] alive on Feb 17 1944.

Immediate cause of death	Duration
Brain abscess	4 days
Due to Osteomyelitis of frontal bone	1 week
Due to Frontal sinusitis	18 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Feb 17, 1944

Major findings of operation: Epidural abscess

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M. D.
Address JHH Date signed 2-17-44

G 14179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14179
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 11 4
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 342 Camel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha Cooter Marshall Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Colored	married

6 (b) Name of husband or wife Frank Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day: hr	min
42				

9. Birthplace Columbia, S.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Fields
13. Birthplace S.C.

MOTHER
14. Maiden Name Sarah Blasher
15. Birthplace S.C.

16 (a) Informant Frank Carter
(b) Address 342 S. Camel St

17 (a) (Burial, cremation, or removal) (b) Date thereof Feb 21 1944
(c) Cemetery or crematory W.M. Auburn Cem
Location

18 (a) Funeral director A. Hartlief
(b) Address 918 Bond St

19 (a) FEB 18 1944 (Date rec'd by registrar) Hunter for Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 19 , at M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Rheumatic Fever

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner
Date signed February 17, 1944 per Robert Lee Graham M.D.

(Over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-1180 AB-86354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 1-1180 Registered No. 12 1a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Pearl St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ighant Bailey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mary Belle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-20-1900

8. AGE: Years	Months	Days	If less than one day
41	4	22	hr. min

9. Birthplace Tenn. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Bailey
13. Birthplace ?

MOTHER
14. Maiden Name Fannie Snead
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 28 1941 (month, day, year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Date received FEB 13 1941 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH [illegible] 19[illegible] at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19[illegible] to [illegible] 19[illegible], and that I last saw h[illegible] alive on [illegible] 19[illegible]

Immediate cause of death	Duration
(a) Uremia	?
Due to (b) Nephrosclerosis	?
Due to (c) Hypertensive cardiovascular disease with congestive failure	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy [illegible]

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence [illegible] M
(c) Where did injury occur? (Specific place) (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 2/7/41 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically

G 14181 ✓ G 14181

446833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No.

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 4 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 4345 Park Heights Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Isadore Silbermann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: NANNY

6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 12-16-92

8. AGE: Years: 51 | Months: 2 | Days: | If less than one day: hr min.

9. Birthplace: GERMANY (Town, county, and state)

10. Usual Occupation: Butcher

11. Industry or business

FATHER

12. Name: Heinemann Silbermann

13. Birthplace: Germany

MOTHER

14. Maiden Name: Minna Goldberg

15. Birthplace: Germany

16 (a) Informant: Records

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-44 (month) (day) (year)

(c) Cemetery or crematory: Rosedale

Location: Philadelphia Rd & Hamilton Ave

18 (a) Funeral director: Jack Levin Inc

(b) Address: 1439 E. Baltimore St

FEB 18 1944 (b) Huntington Williams M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1944 at 7:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1943 to Feb 17 1944, and that I last saw HIM alive on Feb 17 1944

Immediate cause of death: Carcinoma of the lung — Duration

Due to: C metastases

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: John R. Birmingham M. D.

Address: JHH Date signed 2-18

VS 150

4182

HEALTH DEPARTMENT—CITY OF BALTIMORE

4182

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OR BALTIMORE: (No. 35 & 2 Eastern Ave St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Caroline Augusta 26-4

If U. S. Veteran specify WAR

(a) Residence: No. 35 & 2 Eastern Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Jaquish

6. DATE OF BIRTH (month, day, year) May 10 1858

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
85	8	30 24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Own home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Germany

FATHER

13. NAME Christopher Krumph

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Amelia Jaquish

(Address) 35 & 2 Eastern Ave

18. BURIAL, CREMATION, OR REMOVAL Burial

Place St. Mathews C. Date Feb 18 1944

19. UNDERTAKER John J. McCaffrey

(Address) 2534 Jefferson St.

20. FILED FEB 18 1944 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 15, 1944

22. I HEREBY CERTIFY, That I attended deceased from Sept 15 1943 to Feb 15 1944

I last saw h[illegible] alive on Feb 13 1944 Death is said to have occurred on the date stated above, at 10 PM m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerotic C V Disease	
Chronic myocardial insufficiency	1-1-44
Other contributory causes of importance: None	

Was an operation performed? None Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? No Date of injury ... 19...

Where did injury occur? None

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Isaac Jennick M. D.

(Address) 512 East Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G 14183~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G 14183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1837 Bolton St.
(c) Hospital or institution:

14-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 Bolton St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME LAFAYETTE B. LELAND

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary C.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 30, 1869

8. AGE: Years: 74 | Months: 9 | Days: 16 | If less than one day: hr. min

9. Birthplace: Lancaster Co., Va. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: John Leland
13. Birthplace: Va.

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mrs. Mary C. Leland
(b) Address: 1837 Bolton St. 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/19/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received by registrar: FEB 18 1944 (b) ~~Huntington~~ Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1944, to Feb. 16 1944, and that I last saw h[illegible] alive on Feb 16 1944.

Immediate cause of death: Coccinoma of Stomach — Duration

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Thos. H. Kelly M. D.
Address 1939 Edmondson Date signed 2/17/44

14184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G 14184
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 N. Wolfe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Catherine Newleiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1863

8. AGE: Years	Months	Days	If less than one day
80 81	3	12	hr. min.

9. Birthplace Fullerton, Balto Co. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Newleiser
13. Birthplace Germany

MOTHER
14. Maiden Name Clara Whitekemper
15. Birthplace Germany

16 (a) Informant Mrs. Louise Hyman
(b) Address 1605 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Road

18 (a) Funeral director Geo. Fink & Son
(b) Address 811 N. Wolfe St.

FEB 18 1944
(Date received by local registrar) (b) Huntington Williamsport

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1944, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 18 1944, to 2/17 1944 and that I last saw her alive on 2/17 1944.

Immediate cause of death Arteriosclerotic cardiac vascular disease

Due to Heart failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7
1 18 1944

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen G. Longenecker M. D.
Address 1605 N Gay St Date signed

G 14185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

G 14185 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison st
(c) Hospital or Institution: Nursing Home 15 E
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Fairmount Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary A Gosnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Winfield Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1860

8. AGE: Years 83 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Balto Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James McKinney

13. Birthplace Phila Penna

MOTHER 14. Maiden Name Yardley

15. Birthplace Maryland

16 (a) Informant Dr Howland Gosnell

(b) Address 3500 Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Frederick Ave

18 (a) Funeral director John R Kenny.

(b) Address 134 N Leads Ave

19 FEB 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1944 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to Feb 15 1944 and that I last saw h[illegible] alive on Jan 14 1944.

Immediate cause of death	Duration
Cardiac decompensation	4 days
Due to Generalized arteriosclerosis	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thelma F. Stutzman M. D.

Address 6 Biddle St Date signed 2/17/44

VS 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G 14186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 WASHington BLVD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 WASHington BLVD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Athena Angeledes

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOW

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace GREECE (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business

FATHER
12. Name NICHOLAS ANGELEDES
13. Birthplace GREECE

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GREECE

16 (a) Informant SAVAS ANGELEDES
(b) Address 813 WASHINGTON BLVD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 19 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location WOODLAWN MD

18 (a) Funeral director AMBROSE INC
(b) Address 414 N. FRANKLINTOWN RD

19 FEB 18 1944 Huntington Williams

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17-1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10-1944, to 2-17-1944 and that I last saw him alive on 2-17-1944

Immediate cause of death: Acute Heart Failure — Duration:
Due to: Myocarditis
Due to: Senility
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 6 [illegible] Date signed 4/6/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G 14187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3033 Matthews St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3033 Matthews ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Almira F. Griffin

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of ~~husband or~~ wife Harry C Griffin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 15th 1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	11	0		

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name George Drabing
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Murray
15. Birthplace Unknown

16 (a) Informant Edward L. Griffin
(b) Address 2824 Belmont Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 2/18/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 Filed FEB 18 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15th 1944 at 2-45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1944 to Feb. 15 1944 and that I last saw h~~er~~ alive on Feb. 15 1944

Immediate cause of death: Carcinoma - Stomach — Duration: 3 yrs.
Due to
Due to
Other Conditions: Arteriosclerotic Cardio-Renal ? —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. S. Blum M.D.
Address 506 E. Preston Date signed 2/16/44

VS 150

14188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 14188

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 100 N. Broadway
(b) Street address ~~834 N. Kenwood Ave~~
(c) Hospital or institution: Church Home + Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 N. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mamie Klein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/1883

8. AGE: Years	Months	Days	If less than one day
60	2	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name John Henry Davis
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Elizabeth Moulder
15. Birthplace Cumberland Md.

16 (a) Informant Records
(b) Address Church Home & Infirmary

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Extended

18 (a) Funeral director Wm Cook Inc
(b) Address 127 St. Paul St

19 (a) FEB 18 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1944, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1944 to 2/17 1944, and that I last saw her alive on 2/17 1944.

Immediate cause of death: Cerebral accident.

Due to Hypertension
Diabetes Mellitus

Due to Fracture, left Patella
Infection, left knee, post op

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/28/44.

Major findings of operation: Comminuted fracture, left patellar

of autopsy: not done

Duration: 3 day ? ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 1/27/44 at ? M
(c) Where did injury occur? Balt. (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Fell on by cellar steps

23. Signature J. M. Keller M. D.
Address Church Home + Hosp Date signed Feb. 17

For Dr Robt E Graham, by Howard S. Mankin, M.D.
Baltimore Md

14189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

G 14189
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 Normal Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Normal Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Leonard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband Paul Leonard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13th 1855

8. AGE: Years	Months	Days	If less than one day
88	5	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George F. Metzger
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Marie Zaechlein
15. Birthplace Germany

16 (a) Informant Irene Leonard
(b) Address 1603 Normal Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 18 1944 (Date rec'd by Local Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16th 1944, at 4a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25th 1944 to Feb. 16th 1944. and that I last saw h alive on Feb. 15th 1944.

Immediate cause of death: Myocardial Insufficiency — Duration: about 6mo.

Due to -----

Due to ------

Other Conditions: Enlarged Liver & Secondary Anemia — Duration: unknown
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas W. Margetrage M.D.
Address 401 E. 25th. St. Date signed 2/17/44

VS 180

G 14190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14190
Registered No.

122a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. Garrison Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Martin Wigner

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-5038

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Charlotte Wigner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 1865

8. AGE: Years	Months	Days	If less than one day
78	10	5	hr. min.

9. Birthplace Garrison Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Janitor at Garage

FATHER
12. Name John Wigner
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Charlotte Wigner
(b) Address Garrison Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Frank H. Mitchell Sons
(b) Address Pikesville Md.

FEB 18 1944
(Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17-44 19 at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1944 to 2-17 1944 and that I last saw him alive on 2-17 1944.

Immediate cause of death Cardio-Respiratory failure — Duration

Due to Post Operative Bilateral Branchial Pneumonia

Due to Post operative Pulmonary Infarct

Other Conditions Rt. Herniaplasty
(Include pregnancy within 3 months of death)

Date of operation 2-4-44

Major findings of operation: Bilateral Indirect Inguinal Hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Mantell M. D.
Address Union Memorial Hosp Date signed 2/19/44

14191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14191
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Chalgrove Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-17
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Chalgrove Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUBEIN GOLDSTEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W.

6 (b) Name of husband or wife Jennie

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
65				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Russia

MOTHER 14. Maiden Name Dora
15. Birthplace Russia

16 (a) Informant Mrs. Ezra Rudt
(b) Address 1126 Chalgrove Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phila Rd. & Bowleys Lane

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Balto St

FEB 18 1944 Date rec'd by registrar — Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/44 19 .. at 2 a.s. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10-44 19.. to 2/18-44 19.. and that I last saw h— alive on 2/17-44 19..

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Arterio-sclerosis (Hypertension) — 2 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lantz M.D.
Address Temple Garden Date signed 2/18-1944

VS 160

G 14192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14192
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3246 Abell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3246 Abell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Henry Winter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emily Louise Winter
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Sep 21 1877

8. AGE: Years	Months	Days	If less than one day
66	4	27	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired Merchant
11. Industry or business

FATHER
12. Name George Winter
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Annie Roberts
15. Birthplace Baltimore Md

16 (a) Informant Emily Louise Winter
(b) Address 3246 Abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Harry Mannacock
(b) Address 4204 Ridgewood Ave

19 (a) FEB 18 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1944 at 2:1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1. 1943. to Feb. 17 1944. and that I last saw h alive on 19

Immediate cause of death
Acute Dilatation of Heart
Due to Chronic Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
1 Year
several years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thurl. C Black M. D.
Address Med Arts Date signed 2-18-44

14193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓

G 14193
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7714 Daniel Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) VS
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 7714 Daniel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie B. Rickey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Samuel Rickey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/31/52

8. AGE: Years	Months	Days	If less than one day
91	10	19	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Wm. P. Lauder
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Miller
15. Birthplace Md.

16 (a) Informant Mrs. Wm N. Grimes
(b) Address 7714 Daniel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Harford Co. Md.

18 (a) Funeral director Sagsahan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) FEB 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18th 1944, at 3:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 3 1944 to Feby 18 1944. and that I last saw her alive on Feby 11 1944.

Immediate cause of death: Cardiac decompensation — Duration: Feby 11 1944

Due to

Due to Chronic Myocarditis — a number 7 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris B. Green M. D.
Address 3009 Evergreen Ave Date signed 2/18/44
Baltimore 4 Maryland

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14194 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N. Amity Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Annie Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63 62			hr. min.

9. Birthplace Westpoint Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Flemms Williams
13. Birthplace Hamilton Va.

MOTHER
14. Maiden Name Lucinda
15. Birthplace Hamilton Va.

16 (a) Informant Mary Harrison
(b) Address 1712 Johnson St. N.W. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Wm. Kate & Williams
(b) Address 1924 N. Longwood St.

19 (a) Huntington Parkway, Md. (Date rec'd by registrar) Registrar

FEB 18

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17. 19 44, at 10:12 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. Z. Wallenmeyer M.D. Medical Examiner.
Date signed 2-15-44

VS 151

14195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

x V 46F

G 14195
Registered No. 11275

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Greenhaven
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Frieda Bonnett

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife CHARLES BONNET
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 31 1887

8. AGE: Years	Months	Days	If less than one day
56	6	18	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name GEORGE KLECH
13. Birthplace GERMANY

MOTHER
14. Maiden Name ELIZABETH SCHMARKER
15. Birthplace GERMANY

16 (a) Informant CHARLES BONNETT (HUS.)
(b) Address GREEN HAVEN MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 21/44 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location GLENBURNIE MD.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) FEB 18 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18th 1944 at 3 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1943 to 2-18- 1944, and that I last saw her alive on 2-18 1944.

Immediate cause of death [illegible] Possible Ca of liver. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A H Joyce, Jr M. D.
Address St Agnes Hospital Date signed 2-18-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 6 14196

14196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Riviera Apts. Linden Ave. & Lake Drive.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Riviera Apts. 901 Lake Drive (If rural give location)

(e) If foreign born, how long in U. S. A.? years

13

3 (a) FULL NAME HARRY B. WOLF

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1880

8. AGE: Years	Months	Days	If less than one day
63	8	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Attorney

11. Industry or business

FATHER 12. Name Jacob Wolf,

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mollie Furstenberg,

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Sarah C. Wolf,

(b) Address Riviera Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/44. (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Balto. Md.

18 (a) Funeral director Harold Sons & Saivant & Sons

(b) Address 1902 Eutaw Place.

FEB 18 19 44 (b) (Date received by Registrar) Registrar

Huntington Hillsboro, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17th. 1944 at AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25, 1943, to Feb. 16, 1944, and that I last saw him alive on Feb. 16, 1944, at 6.30PM

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to arteriosclerosis and hypertension.	
Due to	
Other Conditions Chronic nephritis.	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles F. Austrian M. D.

Address 1417 Eutaw Place Date signed 2/17/44

Chas. AUSTRIAN

G 14197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 14197

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home of Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Home
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Home for Incurables (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Mitchell Alford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2. 1876

8. AGE: Years 67 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Maryland. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James H. Alford
13. Birthplace Baltimore Maryland.

MOTHER
14. Maiden Name Mary Virginia Mitchell
15. Birthplace Dorchester Co. Md.

16 (a) Informant Margaretta Alford
(b) Address 107 E. 25th St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 19/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director John A. Mitchell Sons
(b) Address 1900 Eutaw Place

Filed Feb 18 1944 (Date filed by Registrar) (b) Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17, 1944, at 7.45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1938 to 2/17 1944, and that I last saw her alive on 2/17 1944.

	Duration
Immediate cause of death: Coronary Thrombosis	9 minutes
Due to:	
Due to: Rheumatoid Arthritis	14 yrs.
Other Conditions: Laryngitis	10 Days.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Harsperger

Address 214 Medical Arts Bldg. Date signed 2/18/44

V8 8

G 14198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92a

Registered No. G 14198

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3251 Chestnut Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3251 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Nelson Conway

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-8425

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna G. Conway

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 - 1890

8. AGE: Years 53 | Months 5 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore - Maryland
(Town, county and state)

10. Usual Occupation Foreman - American

11. Industry or business Hammer + Piston Ring

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Amanda
15. Birthplace

16 (a) Informant Edna Gertrude Conway
(b) Address 3251 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 - 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Ellsworth Cremacost
(b) Address 3911 Liberty Heights Ave.

19 (c) FEB 18 1944 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1944, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941, to Feb 1944, and that I last saw him alive on Feb 12 1944.

Immediate cause of death: Pulmonary Edema — Duration: 4 days

Due to: Cardiac Insufficiency — Duration: several months

Due to: — Duration:

Other Conditions: Chronic Bronchitis — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address 900 N Broadway Date signed 2-17-44

VS 8

14199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. 14199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene St
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Kenseth St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Kovack

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-6-1939

8. AGE: Years	Months	Days	If less than one day
5 yrs	1	9	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Kovack
13. Birthplace New Jersey

MOTHER
14. Maiden Name Nellie Beall
15. Birthplace Frederick Md

16 (a) Informant Mrs George Kovack
(b) Address 1511 Kenseth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md.

18 (a) Funeral director Minnie Cooke Dyer
(b) Address 1600 W. North Ave

19 (a) FEB 18 1944 (Entered by Registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15 1944, at 2 PM

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Mitral Heart

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles J. Sulinski M.D. Medical Examiner.
Date signed 2/15/44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 3-4200

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 William St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 William St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Rnark

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Elsie M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9 1865

8. AGE: Years	Months	Days	If less than one day
78	6	7	hr. min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Ship Carpenter

FATHER
12. Name Edward W Rnark
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs Elsie M Rnark
(b) Address 914 William St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/44 (month) (day) (year)

(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director William M Marecks
(b) Address 715 Light St

FEB 18 1944

19 (a) (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1944, at 9:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1944 to Feb 16 1944, and that I last saw h[illegible] alive on Feb 16 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	2
Due to Hypertension	1 year
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1226 N Charles St Date signed 2/17/44

G 14201 ✓ G 14201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 35

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Russell St
(c) Hospital or institution: ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) _____
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County _____
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Russell St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) ✓
If yes, name country _____

3 (a) FULL NAME Lillian Minton

3 (b) If veteran, name war	3 (c) Social Security Account No. 212-20-2675

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife _____
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 27 1910

8. AGE: Years	Months	Days	If less than one day
33	5	17	_____ hr. _____ min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Holite Rubber mfg Co
11. Industry or business

FATHER
12. Name George Smith
13. Birthplace Norge Va

MOTHER
14. Maiden Name Claudia Saunders
15. Birthplace Chester Maryland

16 (a) Informant Elizabeth Lee
(b) Address 518 So Paca Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A Lichy
(b) Address 401 Wash. Mount Street

19 (a) _____ (b) _____
(Date received by registrar) Huntington Williams, Registrar
FEB 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1944 at 5 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1944 to Feb 15 1944. and that I last saw her alive on Feb 15 1944.

Immediate cause of death Measles — Duration 2 days

Due to _____

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Edward W. Lange M. D.
Address 1665 W. Baltimore St Date signed 2/16/44

G 14202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14202 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Tuscanny Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Bonan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M MEZGER

6 (b) Name of husband or wife Lillian ~~Bonan~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Massachusetts (Town, county, and state)
10. Usual Occupation Executive
11. Industry or business Department Store

FATHER
12. Name Frank Bonan
13. Birthplace New Brunswick, Canada

MOTHER
14. Maiden Name Honorah Hart
15. Birthplace Ireland

16 (a) Informant Wife - Mrs. Lillian Bonan
(b) Address 304 Tuscanny Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. O. Means & Son
(b) Address 605 W. Saratoga St.

FEB 18 1944
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1944, at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1944, to Feb. 17, 1944, and that I last saw him alive on Feb. 17 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebro Vascular accident	
Due to Hypertension	
Other Conditions Auricular Fibrillation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Hornbrook M. D.
Address Mercy Hospital Date signed 2/12/44

CUCHUMBER ✓

14203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 14203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Dolphin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Cuchumber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Etta Cuchumber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace St. Mary Co., Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Cuchumber
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Etta Cuchumber
(b) Address 214 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Balto. Md.

18 (a) Funeral director Mrs. Frances A. Hensley
(b) Address 518 W. Biddle St

19 (a) FEB 18 1944 (Date rec'd by registrar) (b) Washington [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1944, at 6A. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wallenmeyer M.D. Medical Examiner.
Date signed 2-18-44.

VS 151

Correct name, with SURNAME FIRST. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 14204 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Gold Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME LEANORA E. BAILEY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1883

8. AGE: Years	Months	Days	If less than one day
60	4	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Government Employee
11. Industry or business

FATHER
12. Name Alfred Bailey
13. Birthplace Md.

MOTHER
14. Maiden Name Annie E. Lane
15. Birthplace Md.

16 (a) Informant Mr. Heber E. Watts
(b) Address 508 Gold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hersley
(b) Address 578 W. Biddle St.

19 (b) FEB 18 1944 (Date rec'd by registrar) Hunting for Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1944 at 6 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3/ 19 44 to 2/16 19 44 and that I last saw h alive on 19

Immediate cause of death	Duration
Pt Lobar Pneumonia	3 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H W Elcano
Address 1131 Harlem Ave Date signed 2/18/44

G 14205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 14205
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE BROOKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1869

8. AGE: Years	Months	Days	If less than one day
74	4	16	hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name John Chase
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Alethia ?
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

FEB 18 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16-44 19 at 1:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1943 to Feb 17 1944, and that I last saw h[illegible] alive on Feb 17 1944. 1944

Immediate cause of death Cardio-Vascular Renal — Duration ?

Due to

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. McAuley M. D.
Address 1200 Druid Hill Ave Date signed Feb 18

G 14206

AB-84864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G 14206

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos-17 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Reginald Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Sarah (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan, 4-1885

8. AGE: Years	Months	Days	If less than one day
59	1	11	hr · min.

9. Birthplace British West Indies (Town, county, and state)
10. Usual Occupation General Laborer
11. Industry or business

FATHER
12. Name Benjamin (D)
13. Birthplace ?

MOTHER
14. Maiden Name Sarah Dean (D)
15. Birthplace British West Indies

16 (a) Informant BALTIMORE CITY HOSPITALS RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Herndon
(b) Address 578 W. Biddle St.

19 (a) FEB 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15 1944 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1943 to 2-15 1944, and that I last saw him alive on 2-15 1944.

Immediate cause of death: Carcinoma of Stomach — Duration: 15 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald Bobbett M. D.
Address Balto City Hosp Date signed 2-15-44

(a) 14207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

14 Registered No. 14207

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothy Ruff Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26

8. AGE: Years	Months	Days	If less than one day
18			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name Charles Britton
13. Birthplace Md

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Md

16 (a) Informant Mrs Mary Ruff Brown
(b) Address 1303 Argyle Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md

18 (a) Funeral director Mr Francis A. Hensley
(b) Address 548 W. Baltimore St.

19 (a) 2-19-1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1944, at 12:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1944 to 2/17 1944, and that I last saw her alive on 2/16 1944.

Immediate cause of death — Duration
Respiratory failure
Due to Meningitis 9 days
Due to
Other Conditions Pregnancy Extrauterine
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: Miliary tuberculosis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn O. Swinnerton M. D.
Address University Hosp. Date signed 2/17/44

VS 3

14208

AB-86405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 14208
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 E. Baltimore, Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Pierce

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-20-1873

8. AGE: Years	Months	Days	If less than one day
71	-	22	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Dave Pierce
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address RECORDS

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory JOHN HOPKINS MEDICAL SCHOOL FEB 18 1944
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 18 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1944 at 7.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1944 to 2/12 1944.
and that I last saw him alive on 2/12 1944.

Immediate cause of death (a) Acute C.V.A.
(b) Coronary occlusion
Due to (c) A.S.C.V.D.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
(a) ?
(b)
(c)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seyman M.D.
Address 313 E. H Date signed 2/16

10740

G 14209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G 14209

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 S. Paca Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edna Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Queen Anne Co Md (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name John C Smith
13. Birthplace G.A. Co Md

MOTHER
14. Maiden Name Taylor
15. Birthplace Unknown

16 (a) Informant Blair L. Smith
(b) Address Chestertown Md R.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Church Hill
Location Church Hill Md

18 (a) Funeral director Elton L. Lane
(b) Address Church Hill Md

FEB 18 1944 (Date rec'd by Registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1944 at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraser M.D. Medical Examiner.
Date signed February 17, 1944

VS 161

Please write plainly, with ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14210 Bombergue G 14210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH Old Spring Nursing Home

CITY OF BALTIMORE: (No. 2101 Old Spring Lane St., Ward) 15

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 69 yrs. 5 mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Emma Bombergue

If U. S. Veteran specify WAR

(a) Residence: No. 2101 Old Spring Road St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write word): Widow

5a. If married, widowed, or divorced, HUSBAND of (or WIFE of): Edw. M. Bombergue

6. DATE OF BIRTH (month, day, year): Sept 2. 1874

7. AGE: Years 69 | Months 5 | Days 14 15 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Balto Md

FATHER

13. NAME: Everhardt Decker

14. BIRTHPLACE (city or town) (State or country): Germany

MOTHER

15. MAIDEN NAME: Elizabeth Buermer

16. BIRTHPLACE (city or town) (State or country): Germany

17. INFORMANT: C. Bissell

(Address): 607 Lyndhurst St

18. BURIAL, CREMATION, OR REMOVAL: Place S. London Date OK 2/20/44 19

19. UNDERTAKER: Geo H. Zemlock

(Address): 522 N. Lyndhurst St

20. FILED FEB 18 1944 H. Livingston Hill Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Feb 17, 1944

22. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1943 to Feb 17, 1944

I last saw h[illegible] alive on Feb 15, 1944. Death is said to have occurred on the date stated above, at 9:41 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage	
Other contributory causes of importance:	

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Wm H Patterson M. D.

(Address) 2324 Reisterstown Rd

Vol 0

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 14211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 14211 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 E. Preston St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 E. Preston t (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME John M. Renehan

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-3717

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Margaret Hooda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 22 1890

8. AGE: Years	Months	Days	If less than one day
53	10	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name John M. Renehan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Delia M. McDonald
15. Birthplace Ireland

16 (a) Informant Frank Renehan
(b) Address 3110 Brenden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Signature of registrar) (b) Date received FEB 18 1944 Harrington Williams M.D.
vs hv

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 17 1944, at 1:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1944 to 2/17 1944 and that I last saw h alive on 2/17 1944

Immediate cause of death Acute Lobar Pneumonia — Duration

Due to infection

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Augusta St Date signed 2/18/44

G 14212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

G 14212 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E 23d St.
(c) Hospital or institution: Beck Diagnostic Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 930 N Callington Ave (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Zak

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wh.	married

6 (b) Name of husband ~~or wife~~ Frank Zak
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) July 10, 1873

8. AGE: Years	Months	Days	If less than one day
70	7	5	____ hr. ____ min.

9. Birthplace Chezoslovania (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Joseph Fink
13. Birthplace Chezoslovia

MOTHER
14. Maiden Name Mary Fink
15. Birthplace Chezoslovia

16 (a) Informant Mary Machovec (family)
(b) Address 1930 N Callington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md

18 (a) Funeral director Frank Brach Son
(b) Address 900 N. Chester St

19 (a) FEB 19 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1944, to Feb 15 1944, and that I last saw her alive on Feb. 15 1944.

Immediate cause of death Congestive Heart failure — Duration 2 days
Lobar Pneumonia — 10 days
Due to Grippe — 2 mos.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry G. Beck M.D.
Address 100 E. 23d St Date signed Feb 15-44

14213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 14213
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4501 Valley View Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4501 Valley View (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E. Straney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Matilda M. nee Bloomer If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Monitor Controller
11. Industry or business

FATHER
12. Name Edward Straney
13. Birthplace Louisville Ky.

MOTHER
14. Maiden Name Elizabeth Brown
15. Birthplace Maryland

16 (a) Informant Matilda M. Straney
(b) Address 4501 Valley View

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Harford Road

19 (a) FEB 19 1944 (Date rec'd by registrar) (b) Huntington Willis, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1944, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1944 to 2/16 1944 and that I last saw h[illegible] alive on 2/11 1944

Immediate cause of death Cerebral Embolism — Duration 2 weeks

Due to Arteriosclerotic Heart disease — 2 YRS +

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Haden M. D.
Address 6304 Belair Rd Date signed 2/17/44

14214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G 14214
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George
(c) City or town Hyattsville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4501 Rhode Island Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			18 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Refused
13. Birthplace

MOTHER
14. Maiden Name Marian Anderson
15. Birthplace Washington D. C.

16 (a) Informant Marian Anderson
(b) Address 4501 Hyattsville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt Peters Cem
Location Baltimore Md

18 (a) Funeral director George A Fuller
(b) Address Tueton Ave & Fayette St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar
FEB 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18- 1944, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16-1944 to 2-17-1944, and that I last saw her alive on 2-18- 1944.

Immediate cause of death	Duration
Congenital Pulmonary atelectasis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pulm. Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Lang M. D.
Address Bon Secours Hosp. Date signed 2/17/44

G 14215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14215 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Mangold st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Mangold st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George D Bruchey

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21 1861

8. AGE: Years 82 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Not Available
13. Birthplace Maryland

MOTHER 14. Maiden Name Martha McCoy
15. Birthplace Maryland

16 (a) Informant Mrs Mary E Shilow
(b) Address 804 Mangold st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-44 (month) (day) (year)
(c) Cemetery or crematory Westminster Mem
Location Baltimore Md

18 (a) Funeral director George G Farley
(b) Address Fulton & Fayette

FEB 19 1944 (b) Registrar Huntington Williams

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18- 1944, at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 to 19, and that I last saw him alive on 2/17 1944

Immediate cause of death: Cerebral Hemorrhage — Duration 10 days
Due to Arteriosclerosis — Duration 3 yrs
Due to Arterial Tension — Duration 3 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nicholas Brown M. D.
Address 7 Mount Blvd Date signed

G 14216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

G 14216 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inserted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland City Morgue
(b) Street address 100 East Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5426 Narcissus Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Robertson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Betty V. Robertson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1910

8. AGE: Years 33 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name Laurence J. Robertson
13. Birthplace Nanjemoy, Maryland

MOTHER
14. Maiden Name Olive Young
15. Birthplace Dentsville, Maryland

16 (a) Informant Laurence J. Robertson
(b) Address 5426 Narcissus Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St

19 (a) FEB 19 1944 Date received by registrar (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1944 at 11:30 A M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Squamous cell Carcinoma of face

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D.
for Medical Examiner.
Date signed 2-18-44.

G 14217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1929 Registered No. G 14217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 Steele Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Steele Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Constance Evelyn Dunborow

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: [illegible]

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel G.
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1868
8. AGE: Years 76 | Months | Days | If less than one day: hr. min.
9. Birthplace: England (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

MOTHER / FATHER
12. Name: Francis A Deekens
13. Birthplace: Holland
14. Maiden Name: Amelia Andrews
15. Birthplace: Ireland

16 (a) Informant: Samuel G Dunborow
(b) Address 2408 Steele Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory: Pound Ridge
Location: Pikesville Md
18 (a) Funeral director: Milburn & Son
(b) Address: 1317 St Paul St
19 (a) FEB 19 1944 (Date filed by registrar) (b) Huntington Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1944 at 3:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Feb 16 1944, and that I last saw h[illegible] alive on Feb 16 1944

Immediate cause of death: Valvular Heart disease — Duration: 7
Due to Arteriosclerosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Samuel H Culver M. D.
Address 56 11 Pimlico Rd Date signed 2/18/44

CULVER

VS 150

14218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 180

G 14218
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital (XZ)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew J. Goodman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband of ~~wife~~ Harry V. Goodman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22nd 99

8. AGE: Years	Months	Days	If less than one day
28	9	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name William Cumpton
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Florence Linton
15. Birthplace Wilmington N. C.

16 (a) Informant Francis M. Cumpton
(b) Address 401 E. 22nd St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery ~~crematory~~ London Park
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1207 St. Paul St

19 (a) FEB 19 1944 (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1944, at 11:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 1a/b
(a) Date of injury February 13, 1944 10:00 A.M.
(b) Where did injury occur? 401 E. 22nd St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? At home
(d) Means of injury Burned in conflagration

23. Signature Robert Lee Gunther M.D. Medical Examiner.
Date signed February 17, 1944

G 14219

AB-86438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 14219

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2316 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Joseph Arms trong

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20-1872

8. AGE: Years	Months	Days	If less than one day
71	10	24 23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Old Age Pension
11. Industry or business

FATHER
12. Name John Armstrong
13. Birthplace Md.

MOTHER
14. Maiden Name Ella ?
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address RECORDS

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Balto. Md.

18 (a) Funeral director Archibald A. Gadsby
(b) Address 2101 McCulloh St. Baltimore

FEB 19 1944 (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1944, at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1944 to 2/13 1944, and that I last saw him alive on 2/13 1944

Immediate cause of death: Bronchopneumonia — Duration: 5

Due to

Due to

Other Conditions A.S.C.V.D. recent C.V.A.; dehydration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

E. L. Sergeman M. D.
Signature
Address BCH Date signed 2/16

(over)

G 14220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X / 160 c

G 14220 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1400 Caroline St.~~ 7807 German Hill Rd. Dun
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Bober, Baby Boy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 18, 1944

8. AGE: Years	Months	Days	If less than one day
			hr. 10 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank W. Bober
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alma Marie Amos
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 2/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) Date received (b) Registrar Huntington Williams M.D.

FEB 19 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1944 at 12:20 pm

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1944 to Feb. 18, 1944 and that I last saw him alive on Feb. 18, 1944.

Immediate cause of death Asphyxia due to strangulation. | Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Ballweg M. D.
Address St. Joseph's Hosp. Date signed 2/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 14221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 N. Milton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-12
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERLANDO BUTERA

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/25/54

8. AGE: Years	Months	Days	If less than one day
89 yrs.	8	23	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Frank Butera
(b) Address 1432 N. Patterson Pk. Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or ~~CREMATORY~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 FEB 19 1944 Huntington Williams M.D. Registrar
Date received

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1944 to 2/18 1944, and that I last saw him alive on 2-18 1944.

Immediate cause of death	Duration
Myocardial degeneration	10 yrs
Due to Senile arteriosclerosis	
Due to	
Other Conditions Myocardial Arteriosclerosis	3 days

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Paul Miller
Address 1 S or N Broadway Date signed 2/18/44

14222

AB-86422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 115D

Registered No. 14222

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town.)
(d) Street No. 2312 Essex St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-5075

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23-1910

8. AGE: Years 33 | Months 7 | Days 25 | If less than one day: hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Nelson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Cooke
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John F. Weber
(b) Address 401 St Chester Street

FEB 19 1944 Date rec'd

Arlington Williams Registrar

VP 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 1944, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1944 to 2-17 1944, and that I last saw him alive on 2-17 1944.

	Duration
Immediate cause of death: Mediastinitis-probable	6 days
Due to: Ludwigs Angina	2 wks
Due to:	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation 2-11-44

Major findings of operation: Ludwigs Angina

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B Stell M. D.
Address Balto City Hosp Date signed 2-17-44

G 14223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 14223 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Govans P.O. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 K St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Bernice Parker

3 (b) If veteran, name war

3 (c) Social Security Account No. 242-16-4047

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1909

8. AGE: Years	Months	Days	If less than one day
34	2	11	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel

FATHER
12. Name John Parker
13. Birthplace Durham N. Carolina

MOTHER
14. Maiden Name Mala Parker
15. Birthplace Durham N. C.

16 (a) Informant Maryland General Hosp Rec
(b) Address Linden Ave & Madison Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 19 1944 (month) (day) (year)

(c) Cemetery or crematory
Location Durham N. Carolina

18 (a) Funeral director Mrs Robert A. Elliott Dft.
(b) Address 112 9 N. Carolina St

19 (a) Date received by registrar Feb 19 1944 (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 19 44 at 3 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 2/18 19 44, and that I last saw h[illegible] alive on 2/18 19 44.

Immediate cause of death Lobar pneumonia — **Duration**

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Mayer M.D.
Address Mercy Hosp. Date signed 2/19/44

G 14224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

Registered No. G 14224

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Scott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WELLINGTON G. DAY

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Minnie W. Day
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1/1863

8. AGE: Years	Months	Days	If less than one day
80	4	15	hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Madison L. Day
13. Birthplace New London, Md.

MOTHER
14. Maiden Name Frances E. Miles
15. Birthplace Md.

16 (a) Informant Mrs. Katherine Day Heaton
(b) Address 1411 Bryden Rd., Columbus, O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1944 at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1943 to 2/16 1944 and that I last saw him alive on 2/16 1944

Immediate cause of death: Acute Cardiac Failure — Duration: 1 da

Due to: Generalized Arteriosclerosis — Duration: 5 yr

Due to: Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G. Laukaitis M. D.
Address 6716 Yakona Rd Date signed 2/18/44

For Robt. Lee Graham, by Howard J. Williams, M.D.

G 14225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G 14225

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 Batavia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Batavia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH ANNIE GRINATH

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles O. L. Grinath
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1864

8. AGE: Years	Months	Days	If less than one day
79	7	15	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George F. Hanser
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Freida R. Emerine
15. Birthplace Balto., Md.

16 (a) Informant Miss Helen L. Grinath
(b) Address 3211 Batavia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 19 1944 (Date received by registrar) (b) Huntington Williams, M Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1944, at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to 2/18 1944 and that I last saw her alive on 2/18 1944

Immediate cause of death Carcinoma of stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. W. Colley M. D.
Address 503 Harford Rd Date signed 2/18/44

G 14226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G 14226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Tunbridge Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Tunbridge Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME A. (ANNA) MARTHA TAG

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John H. Tag

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1870

8. AGE: Years	Months	Days	If less than one day
73	5	27	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Ernest Bettenhausen
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Shafer
15. Birthplace Germany

16 (a) Informant Miss Dorothea E. Tag
(b) Address 611 Tunbridge Rd 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 19 1944 (Date rec'd by registrar) (b) [illegible] for Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18/42 to 2/18/44 and that I last saw h[illegible] alive on 2/15/44.

Immediate cause of death: Cerebral arteriosclerosis — Duration 5/18/42

Due to: General arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Leo A. Bauden.

Address 1517 E. Monument. Date signed 2/18/44

14227
449392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G 14227
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 E. 23 St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Johnsen Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-22-02

8. AGE: Years	Months	Days	If less than one day hr.	min.
41	10	23		

9. Birthplace VA (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Green
13. Birthplace VA

MOTHER
14. Maiden Name Mollie
15. Birthplace VA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 19 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 Filed FEB 19 1944 (Date rec'd by Registrar) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1944, at 1155 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1944 to Feb 15 1944, and that I last saw him alive on Feb 15 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to cerebral hemorrhage	2 days
Due to hypertensive and arterio-sclerotic Heart disease	
Other Conditions syphilis. ? myocarditis	3 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Semon M. D.
Address Hopkins Date signed 2-16

14228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

Registered No. G 14228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2839 Reed St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Joseph Banks
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Benson
15. Birthplace Md

16 (a) Informant Naomi Black
(b) Address 1533 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 21 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) FEB 19 1944 (Date rec'd by registrar) (b) [illegible] (Signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1944, at 10:45 P

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Anaemia, Cardiac cirhosis

Due to Syphilitic aortitis & valvulitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed February 17, 1944

G 1225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 1225

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 N. Washington st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva D. Pfarr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2 - 1884

8. AGE: Years	Months	Days	If less than one day: hr.	min.
59	4	15		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Conrad Pfarr
13. Birthplace New York

MOTHER
14. Maiden Name Margaretha Pepperack
15. Birthplace Baltimore

16 (a) Informant Mr. Pfarr
(b) Address 1023 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 21 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Eutaw St

19 (a) (Date received by Local Registrar) FEB 19 1944 (b) Huntingtown, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1944, to Feb. 17 1944, and that I last saw her alive on Feb. 17 1944

Immediate cause of death: Acute Congestive heart failure

Duration 6 hrs.

Due to Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm D Ichart M. D.
Address 701 N. Howard St Date signed 2/19/44

1 2236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

192D

Registered No. 1 2236

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 04.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Harrison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Schyne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2 1867

8. AGE: Years 77 | Months 1 | Days 5 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Schyne

13. Birthplace

MOTHER 14. Maiden Name Lizzie Albert

15. Birthplace

16 (a) Informant Wm. Hirsch

(b) Address 327 N. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Mt. Wilson

Location Lorraine

18 (a) Funeral director Edward W. Kemp

(b) Address 4714 Reisterstown Road

19 (a) (b)

(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1944 at 6:40 P. M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Richard Lee Fratarcangeli M.D.
Medical Examiner

Date signed February 17, 1944

G 14231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G 14231

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1114 William St

(c) Hospital or institution: 1114 William St 24 —

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:

a State Md b County

c City or town Baltimore (If outside city or town limits, write RURAL, and give town)

d Street No. 1114 William St (If rural, give location)

e Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Premature Birth White

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-44

8. AGE: Years — Months — Days — If less than one day hr 15 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER

12. Name Conrad Well White

13. Birthplace Magoffin Co. Kentucky

MOTHER

14. Maiden Name Gaynell Sicke

15. Birthplace Jackson Co. Ohio

16 (a) Informant Gaynell White

(b) Address 1114 W Wm St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL FEB 1 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) FEB 1 1944 Hamilton Williams, M.D. Registrar

(Date rec'd by reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1944 to 2-18 1944, and that I last saw h alive on 2-18 1944.

Immediate cause of death Atelectasis Prematurity - foetal lungs

Duration 15 minutes

Due to Maternal Hypertension

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation —

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Pearl Pass, M.D.

Address 400 W Mount Ave Date signed 2-18-44

VS 150

10741

G 14232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14232

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Willow Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Faulstich (Mrs. Henry) or Caroline Faulstich

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Faulstich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1884.

8. AGE: Years 60 Months 0 Days 8 If less than one day hr min

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Andrew Steele

13. Birthplace Germany

MOTHER 14. Maiden Name Justina Flyer

15. Birthplace Germany

16 (a) Informant Henry Faulstich

(b) Address 15 Willow Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)

(c) Cemetery or crematory Pachwood Cem.

Location Taylor Ave.

18 (a) Funeral director W. W. E. Dippold Sons

(b) Address Lombard & Arch Sts

19 (a) FEB 19 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1944 at 11:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1944, to 2-18 1944, and that I last saw her alive on 2-18 1944.

Immediate cause of death: Pulmonary embolism — Duration

Due to

Due to

Other Conditions: Hypertension

(Including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stephen J. VanLillard M. D.

Address Union Memorial Hosp. Date signed 2-18-44

14237

G 14238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Madison Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Alice Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	Married

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
83			..... hr. ..... min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Blum
(b) Address 1714 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Geo. L. Gibson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 19 1944 (Date filed by Registrar) (b) Hunting to Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 16 1944 at 7.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1943 to Feby 16 1944.
and that I last saw her alive on Feby 16 1944.

Immediate cause of death	Duration
Chronic Nephritis	1 yr.
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
.....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature H. E. Pelletier M. D.
Address 17 W Hamilton Ave Date signed .....

VS 150

B 14234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

832 Registered No. B 14234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME Oscar R. Yantz

3 (b) If veteran, name war .....
3 (c) Social Security Account No 212-18-1530

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 24th 1888

8. AGE: Years	Months	Days	If less than one day
55	5	22	hr. ..... min. .....

9. Birthplace [illegible] Md (Town, county, and state)
10. Usual Occupation Globe Brewing bo
11. Industry or business Laborer

FATHER
12. Name John Yantz
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Oscar Yantz
(b) Address 1703 E Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) FEB 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1944, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed February 17, 1944

14235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C 14235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 E Monument
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 E. Monument (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ella Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1866

8. AGE: Years 77 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name Thomas Reason
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Matilda Grimes
15. Birthplace Harford Co. Md

16 (a) Informant Chas E. Stanley
(b) Address 1209 E. Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs. Robert A. Elliott & Son
(b) Address 1129 N. Caroline St.

19 (a) Filed FEB 19 1944 (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1944, at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1944 to Feb 16 1944 and that I last saw h[illegible] alive on Feb 16 1944

Immediate cause of death: Apoplexy — Duration: 3 days
Due to 1: arteriosclerosis
Due to: Hypertension
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edwin Fisher M.D.
Address 1612 E Monument Date signed Feb 17/44

14236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. D 14236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecelia Conroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Farrell
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial **(b) Date thereof** Feb 22, 1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Whitfield
(b) Address 917 Gramercy Arms

19 (a) 2 19 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 250

MEDICAL CERTIFICATION 7.45p.

20. DATE OF DEATH Feb. 18 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 18 1944 and that I last saw her alive on Feb 18 1944.

Immediate cause of death	Duration
Edema of Lungs	1 day.
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E Northern Ave **Date signed** 2/19-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1950

Registered No. 14237

14237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 E. Hamburg St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 115 E. Hamburg Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Francis Remilleng

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1943

8. AGE: Years | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business -

FATHER
12. Name Milton F. Remilleng
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Doris L. Remilleng
15. Birthplace A. A. Co.

16 (a) Informant Doris L. Remilleng
(b) Address 115 E. Hamburg Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location Annapolis Road

18 (a) Funeral director Hof Kenny
(b) Address Hollins & Gilmor

19 (a) FEB 19 1944 (Registrar) Huntington Williams (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1944, at 9 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation.

Due to Aspiration of Vomitus.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-18-44. 9 A. 24 hr. M.
(b) Where did injury occur? Above address
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Aspiration of Vomitus

23. Signature H E Bollmeier M.D.
Medical Examiner.
Date signed 2-18-44.

G 1+238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

G 1+238
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Boston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DeFatta, John

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1938

8. AGE: Years	Months	Days	If less than one day
5	10	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Charles DeFatta
13. Birthplace Italy

MOTHER
14. Maiden Name Santa Papa
15. Birthplace Italy

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd & Moravia Ave

18 (a) Funeral director Frank J. Lopatrone
(b) Address 2830 E. Baltimore St.

19 (a) (Local Registrar) (b) Huntington Williams M.D. Registrar

FEB 20 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1944, at 12 22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1944 to Feb 18 1944 and that I last saw him alive on Feb 18 1944.

Immediate cause of death	Duration
cardiac arrest	
Due to myocarditis	1 wk.
Due to diphtheria	2 wks.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed 2-18-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 8158 14239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G 14239 Registered No. G-14239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 14 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ? Eager St. 1708 (Female) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James ~~Hardy~~ Holley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1870 ?

8. AGE: Years	Months	Days	If less than one day
72 ?	?	?	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Giley ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Eborg Wilson
(b) Address 1000 Bradley Ave

19 (a) Date received FEB 20 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1944 at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1943 to 2/14 1944. and that I last saw him alive on 2/14 1944.

Immediate cause of death Coronary occlusion (?) ; cerebro-vascular accident (?)
Due to A. S. C.V.D.
Due to
Other Conditions Hyp. arteriosclerosis ; Chr. emphysema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy No post

Duration ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. L. Seigman M.D.
Address BCH Date signed 4/5

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JO #96464

G 14240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14240 Registered No. 3049 - 14240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs. 40 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 850 S. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Hazel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1903

8. AGE: Years	Months	Days	If less than one day
40	9	16	hr min.

9. Birthplace West Indies (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address

19 (a) FEB 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1944, at 5:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1944 to 2/17 1944, and that I last saw him alive on 2/17 1944.

Immediate cause of death C.N.S. lues; tabes dorsalis — Duration 1-2 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M. D.
Address BCH Date signed 2/17

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14241 ✓ G 14241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 Registered No. G-14241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 Bowers Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 232 Bowers Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank E. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1890

8. AGE: Years	Months	Days	If less than one day
53	8	24	hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Beverly Jackson

13. Birthplace Washington, D.C.

MOTHER 14. Maiden Name Margaret Jordon

15. Birthplace Va

16 (a) Informant Margaret Thomas

(b) Address 2436 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley ave

FEB 20 1944 (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1944 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1944 to Feb 14 1944. and that I last saw h[illegible] alive on Feb 14 1944.

Immediate cause of death Heart hemorrhage — Duration 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address [illegible] Date signed 2/17 M. D.

Please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14242

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 14242 Registered No. 5-17242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Simpson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68 67			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Charles Simpson
(b) Address 25 S. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Belair Rd

(b) Date received (by registrar) FEB 20 1944 (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1944, at 12:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Wallace M.D. Medical Examiner.
Date signed 2/23/44

G 14243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 14243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 W Strickers St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1961
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 W. Strickers St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Cornil Harris.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife Conrad Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1909

8. AGE: Years	Months	Days	If less than one day: hr.	min.
34	6	24		

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name John W. Williams
13. Birthplace N.C.

MOTHER
14. Maiden Name Carrie Davis
15. Birthplace N.C.

16 (a) Informant Conrad Harris
(b) Address 531 W. Strickers St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19-44 (month) (day) (year)
(c) Cemetery or crematory Raleigh
Location

18 (a) Funeral director Mrs Katie Williams
(b) Address 322 N. Schroeder St.

19 (a) (Signature of registrar) (b) Huntingtor Williams, M.D.

FEB 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1944 10 am M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1943 to 2/17 1944
and that I last saw h alive on 2/17 1944

Immediate cause of death	Duration
Hypertension Type Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ivan Bricker
Address 601 N Calhoun St Date signed 2/19/44 M D

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Accurate and correct age is especially important.

G 14244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 14237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Myrtle ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? Oct 25 1898

8. AGE: Years	Months	Days	If less than one day
45-50 (?)	3	20	hr. min.

9. Birthplace Md. Erie Pa (Town, county, and state)
10. Usual Occupation None given
11. Industry or business

FATHER — 12. Name	Not Frederick C Smith given
FATHER — 13. Birthplace	Florida Error
MOTHER — 14. Maiden Name	Not Elenora Erickson given
MOTHER — 15. Birthplace	Don't know

16 (a) Informant Mrs Alice Johnson
(b) Address 1309 Myrtle Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. R. Co
18 (a) Funeral director Harry M Chase & Son
(b) Address 638 N. Eutaw St.
19 (a) FEB 20 1944 (Date rec'd by registrar) (b) Huntingtown Prince Georges, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1944, at 6:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1944, to death 19, and that I last saw her alive on 2/14 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Ventricular block	8 days
Due to Pneumonia and empyema	22 days
Other Conditions Pneumococcus Septicemia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Cortical atrophy Pneumonitis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Glen O. Swanson M. D.
Address University Hosp. Date signed 2/15/44

VS 8

G 14245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G 14245 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made on this certificate. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. 33rd & Calvert.
(c) Hospital or institution: Union Mem. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. None.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Louise Bosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1943

8. AGE: Years	Months	Days	If less than one day
	2	21	hr. min.

9. Birthplace Cockeysville, Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Ellwood Bosley
13. Birthplace Maryland.

MOTHER
14. Maiden Name Isabelle C. Thompson
15. Birthplace Maryland.

16 (a) Informant Charle Ellwood Bosley
(b) Address Cockeysville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Febr 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Jerusalem
Location Sparks, Md

18 (a) Funeral director Sanders & Brooks
(b) Address Sparks, Md.

19 (a) FEB 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1944 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16, 1944 to Feb 19, 1944, and that I last saw her alive on Feb 19, 1944.

Immediate cause of death: Respiratory failure — Duration: 3 days.

Due to Bronchopneumonia

Due to

Other Conditions Diarrhea, dehydration & Acidosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James R. McCord Jr. M. D.
Address Union Memorial Hospital Date signed 2-19-44

G 1426 ✓ G 1426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32B

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Use Middle name in full. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Lunacy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Yr Lon
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3427 Royce ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Albert Martin Landsman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1941

8. AGE: Years	Months	Days	If less than one day
2	5	19	..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation .....
11. Industry or business

FATHER
12. Name Raymond Landsman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dorothy A. Paff
15. Birthplace Baltimore

16 (a) Informant Raymond Landsman
(b) Address 3427 Royce Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory New Catherdral Cem
Location Frederick Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1944, at 7:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy and thereon and from the evidence obtained ~~Autopsy~~, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....
Acute Purulent Meningitis Type B.

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Malsbeis M.D.
Medical Examiner.
Date signed 2-19-44

G 14247 ✓ G 14247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished if the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 E. Biddle St.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter F. Dillmann

3 (b) If veteran, name war: Na
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Matilda S. Dillmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 15, 1878

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65,	3	5		

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Inspector at Sparrows pt.
11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Peter Dillmann
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Rose Deice
15. Birthplace: Germany

16 (a) Informant: Mrs. Matilda S. Dillmann
(b) Address: 1020 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 22/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cemetery
Location: 4430 Belair Road

18 (a) Funeral director: Edmund W. Conklin & Son
(b) Address: 4 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18th. 1944, at 5:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9th 1943, to Feb 17th 1944 and that I last saw him alive on Feb 17th 1944.

Immediate cause of death: Pulmonary Edema — Duration: 2 days
Due to: Cardiac Insufficiency — 2 yrs.
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. J. Sanker M. D.
Address: 100 N. Milton Date signed 2/24/44

VS 3

G 14248 ✓ G 14248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

Registered No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if obtainable. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3141 Chesterfield Ave
(c) Hospital or institution:
at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 89 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3141 Chesterfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Mills

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Annie S. Mills
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 5 1853
8. AGE: Years: 90 Months: 6 Days: 13 If less than one day: 12 hr. min.
9. Birthplace: Ireland (Town, county, and state)
10. Usual Occupation: Retired Inspector
11. Industry or business: N.C.R. Dist. Gen. R.R.

FATHER
12. Name: David Mills
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Sarah Tayley
15. Birthplace: Ireland

16 (a) Informant: Mrs Sadie Bibb
(b) Address: 3141 Chesterfield Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 22/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem
Location: 4300 Old Frederick Rd
18 (a) Funeral director: Elmer W. Smithers
(b) Address: 924 E. Lanvale st.
19 (a) (Date rec'd by registrar) (b) Registrar

FEB 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17th, 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1943, to Feb 17 1944, and that I last saw h[er] alive on Feb 17 1944.

Immediate cause of death	Duration
Hypostatic Pneumonia	4 days
Due to Arterio Sclerosis	
Cardio Vascular Renal Dis.	10 yrs
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Thos J Bayley M.D.
Date signed: 2/18/44

Hunting for Wills

G 14249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14249 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 252 S. Exeter St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 252 S. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Zanelotti
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Joseph Zanelotti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 1859

8. AGE: Years	Months	Days	If less than one day
84	6	3	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Corana
13. Birthplace Italy

MOTHER
14. Maiden Name
15. Birthplace Italy

16 (a) Informant Mary Zanelotti
(b) Address 205 S. Bouldin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 1818 E. Baltimore Street

19 (a) [illegible] (Registrar) (b) Huntington Williams, M.D. Registrar

FEB 20 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18. 1944, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1. 1940, to Feb. 18. 1944, and that I last saw her alive on Feb. 17. 1944.

Immediate cause of death Myocarditis (chronic) — Duration 4 yrs.
Due to Arteriosclerosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cronin M. D.
Address 514 Henry Lane Date signed 2/19/1944

G 14250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G 14250 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 W Cross St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 W Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA STEPANOWSKI (STevens)

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER 12. Name ?
13. Birthplace Lithi

MOTHER 14. Maiden Name
15. Birthplace Lith

16 (a) Informant William Stevens
(b) Address 1027 W Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 21-44 (month) (day) (year)
(c) Cemetery or crematory The Cedar Hill Cem
Location

18 (a) Funeral director Joseph Kasmakas
(b) Address 602 Washington Blvd

19 (a) (Date received by registrar) (b) Huntington Williams M.D. (Address)

FEB 20 1944 Vs ter

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 1944 at 3 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1944 to 2-17 1944 and that I last saw her alive on 2-17 1944

Immediate cause of death Cancer of Liver — Duration 3 yr

Due to Metastases — 3 yr

Due to Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F Kasmakas M. D.
Address 602 Washington Blvd Date signed 2/19/44

G 14251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G 14251

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 749 West Lexington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 749 West Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Wokee

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-2496

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1888

8. AGE: Years	Months	Days	If less than one day
55	8	5	hr. min.

9. Birthplace Lithuania
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lithuania

MOTHER
14. Maiden Name ?
15. Birthplace Lithuania

16 (a) Informant Mary Wokee
(b) Address 749 W. Lexington Street

17 (a) Burial (b) Date thereof 2/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director Joseph Kasinskas Inc.
(b) Address 602 Washington Blvd.

19 (a) (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1944 to Feb. 18, 1944, and that I last saw him alive on Feb. 17 1944

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerosis	
Due to Cardiovascular-renal disease	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kirup M.D.
Address 3030 Edmondson Ave. Date signed 2/18/44

G 14252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 14252 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 Ruther st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Ruther st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Married

6 (b) Name of husband or wife Lizzie Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1880

8. AGE: Years	Months	Days	If less than one day
63	-7	-1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Julius Jones
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Richardson
15. Birthplace Unknown

16 (a) Informant Mrs. Jones
(b) Address 1308 Ruther st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lenny M. Holland
(b) Address 1637 Druid Hill Ave.

FEB 20 1944

19 (a) Huntington Williams, M.D. (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/44 19 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14/44 to 2/18/44 and that I last saw him alive on 2/16/44

Immediate cause of death Cardiac Hemorrhage — Duration 2 days

Due to Cerebral arterio sclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature H. Lee Ellis M. D.
Address 1224 Madison Date signed 2/20/44

VS 150

G 14253

G 14253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1846 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1846 Division St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Roberts

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emma R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1872

8. AGE: Years 71 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Eastern Shore Md (Town, county and state)

10. Usual Occupation Elevator Operator

11. Industry or business —

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Elizabeth Lewis

15. Birthplace Maryland

16 (a) Informant Emma R. Roberts

(b) Address 1846 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George F. Holland

(b) Address 691 Druid Hill Ave.

19 (a) FEB 20 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 14 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 6 1944 to Feby 14 1944; and that I last saw h/she alive on Feby 12 1944.

Immediate cause of death Acute Myocarditis

Due to Influenza

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration: 10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Fowler M. D.

Address 691 N. Broadway Date signed 2/19/44

VS 180

449398 14254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G 14254
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 449 Schwartz Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Bowers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	married

6 (b) Name of husband or wife Sarah Bowers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	5	27		

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace Va
14. Maiden Name Amanda ? ?
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lenge H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 20 1944 (b)
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1944 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1944 to Feb. 17 1944 and that I last saw h live on Feb. 17 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to ? Tuberculous pneumonia	5 days
Due to ? Miliary tuberculosis ? Disseminated "	?
Other Conditions arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cepresius M. D.
Address J Hopkins Date signed 2/17

Huntington for Wallace, M.D.

G 11255 Chesley G 11255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 30E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1546 Leslie St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Chesley

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6778

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1896

8. AGE: Years	Months	Days	If less than one day
47 48	-9	-17	hr. min.

9. Birthplace St. Mary's Co. Md. (City, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Louis Chesley
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Matilda Johnson
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Mandy Chesley
(b) Address 1546 Leslie St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory H. Belts
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18 1944 at 6:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1944 to 2-18 1944 and that I last saw him alive on 2-18 1944.

Immediate cause of death Heart failure

Due to Chronic C. Valvular

Due to

Other Conditions Arteriosclerosis - Thrombosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. M. Jones Jr. M. D.

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 14256

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

166 Registered No. 6 14256

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fatimia Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 256 N. Exeter Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Francis Gentile, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife Anna Gentile

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1915

8. AGE: Years 29 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation M. C.

11. Industry or business Bayety N. Club

FATHER 12. Name Giuseppe Gentile

13. Birthplace Italy

MOTHER 14. Maiden Name Grace Giarizza

15. Birthplace Italy

16 (a) Informant Giuseppe Gentile (Father)

(b) Address 256 N. Exeter Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21-44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Redeemer

Location Belair Rd.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Marley St.

19 (a) FEB 0 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1944 at 3:25 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wounds of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2-18-44 2:30 A. M.

(b) Where did injury occur? Hoffman St. + Harlem

(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No.

(d) Means of injury Shot with pistol - revolver

23. Signature T. J. Wollenweber M.D. Medical Examiner

Date signed 2-18-44.

b 14257 BALTIMORE CITY HEALTH DEPARTMENT b 14257
CERTIFICATE OF DEATH 83a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 W. Henrietta
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 W Henrietta (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Laura

6 (c) If alive, give age 1897

7. Birth date of deceased (mo., day, yr.) Aug 5, 1889

8. AGE: Years	Months	Days	If less than one day: hr.	min.
46	6	14		

9. Birthplace Manning S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Railroad

FATHER
12. Name John Johnson
13. Birthplace S C

MOTHER
14. Maiden Name Leah Klingle
15. Birthplace S C

16 (a) Informant Laura Johnson (W)
(b) Address 18 W Henrietta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) FEB 20 1944 (Date received by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1944 at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28, 1944 to Feb 16 1944, and that I last saw h alive on Feb 15 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 2 wks.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Taylor M.D.
Address 522 Parley Ave Date signed 2/8/44

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 14258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard + Madison
(c) Hospital or institution: Md. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 75 Pennsylvania Av.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Mrs. Luella May Lipsey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Harry L.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 21 1879

8. AGE: Years	Months	Days	If less than one day
64	5	29	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Washington Grimes
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucinda Belleson
15. Birthplace Maryland

16 (a) Informant Mrs. Rhoda
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1944 (month) (day) (year)
(c) Cemetery or crematory Westminster
Location ..

18 (a) Funeral director W Bankard & Son
(b) Address Westminster Md.

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1944 at 5:23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1944 to Feb 20 1944 and that I last saw h[illegible] alive on Feb. 20 1944

Immediate cause of death Diabetes mellitus — Duration

Due to .....

Due to .....

Other Conditions Hypertensive arteriosclerotic C.V.D.
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature L. Norman Williams M. D.
Address Md. Gen. Hosp Date signed Feb. 20, 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14259 No. 86471

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G 14259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1333 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Seperated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2nd, 1880

8. AGE: Years	Months	Days	If less than one day
63	5	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Ananis Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Betty Chappell
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Int. Alexander

18 (a) Funeral director Chas H Alexander
(b) Address 12 W McCulloh St

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1944, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1944 to 2/17 1944 and that I last saw h alive on 2/17 1944.

Immediate cause of death Cerebral Embolism — Duration ?

Due to HBVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Serpman M.D.
Address BCH Date signed 2/18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55E

Registered No. 74260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY P. SCHANBERGER

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1870

8. AGE: Years 73 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Lieut. Detective Hdq.

11. Industry or business Balto. Police Dept.

FATHER
12. Name Henry Schanberger
13. Birthplace Md.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mr. Harry P. Schanberger,
(b) Address 1123 Longwood St. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) Certificate filed by Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1944 at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1943 to Feb 19 1944 and that I last saw h living on Feb 19 1944

Immediate cause of death
Cardiac insufficiency
Due to Carcinoma of the neck with metastasis
Due to 4 years
Duration Long

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marion L. Williams M. D.
Address 8263 Fullerton ave Date signed 2, 1944

G 14261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G 14261

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Roland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Roland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE H. STIEGLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irma B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1876

8. AGE: Years	Months	Days	If less than one day
67	6	16	23 hr. min.

9. Birthplace Benson, Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Bauer & Black

FATHER
12. Name George Stiegler
13. Birthplace Germany

MOTHER
14. Maiden Name Elinore Fischer
15. Birthplace Germany

16 (a) Informant Mrs. Irma B. Stiegler
(b) Address 4206 Roland Ave. 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 21 1944 (Date received by Registrar) (b) Lexington Millicent, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1943, to 2/18 1944, and that I last saw h[illegible] alive on 17 1944.

Immediate cause of death: Cancer of lungs secondary to
Due to primary cancer of colon
Due to
Other Conditions

Duration: 1 mon.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty
Address 37 W. Preston St Date signed 2/19/44 M. D.

14262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. B 14262

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 dys
(e) Length of stay in Baltimore (yrs., mos., or days) Life 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N. Bernice Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Anna Helen Deutsch or (Helen C. Deutsch)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-8182

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Leroy F. Deutsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1900

8. AGE: Years	Months	Days	If less than one day
43	6	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name [illegible] Meehan
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Hertzog
15. Birthplace Washington D.C.

16 (a) Informant Hospital records.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 2 (month) 21 (day) 44 (year)
(c) Cemetery or crematory Cathedral Cem.
Location Gatto. Md.

18 (a) Funeral director Wm. J. Tydeneer & Sons
(b) Address Gatto. Md.

FEB 21 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1944, at 10 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1944 to Feb 18 1944, and that I last saw her alive on Feb 18 1944.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Hypertensive cardio-vascular disease & rheumatic H.D. — 10 yrs

Due to Essential arterial hypertension

Other Conditions Coronary thrombosis & Cerebro-vascular accident

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. K. Smythe M.D.
Address Mercy Hosp. Date signed 2/18/44

G 14263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 14263

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 S. Curley
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 S. Curley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Buckins

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-2033

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife James
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49 48			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation War Worker
11. Industry or business

FATHER
12. Name John D. Mashell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Minnie Lutz
15. Birthplace Baltimore, Md.

16 (a) Informant James Buckins
(b) Address 917 S. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Gorman Mill Road.

18 (a) Funeral director John J. Duda
(b) Address 2829 Edmondson Ave.

FEB 21 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 1944 at 4:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio — Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 2/20/44.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. 6 14264

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Lenden Ave
(c) Hospital or institution Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 North Washington St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? Life years

3 (a) FULL NAME John Henry Miller

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-12-5521

4. Sex: Male

5. Colored or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Louise Gies

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1871

8. AGE: Years	Months	Days	If less than one day
72	11	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Baker Helper

11. Industry or business American Stores

FATHER
12. Name August Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Henry August Miller
(b) Address 23 N. Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, Inc.
(b) Address North Ave. & Broadway

FEB 21 1944 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 1944 at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1944 to 2-17 1944 and that I last saw h[illegible] alive on 2-17 1944.

Immediate cause of death	Duration
Pulmonary embolism	
Due to Postatectomy.	
Due to	
Other Conditions Benign Prostatic Hypertrophy Hematuria Bronchitis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations above
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D. Young Jr. M. D.
Address [illegible] Hosp. Date signed 2-17-44

G 14265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 14265 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 Parkside Drive
If Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Parkside Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT WASHINGTON MC DANIEL

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 219-20-9713

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Julia Pearl MC DANIEL
6 (c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Jan. 24, 1871

8. AGE: Years	Months	Days	If less than one day
73	---	23	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired Manager
11. Industry or business: Canton Box Co.

FATHER
12. Name: John Mc Daniel
13. Birthplace: Balto, Md.

MOTHER
14. Maiden Name: Adelaine Henderson
15. Birthplace: Balto. Md.

16 (a) Informant: Robert A. McDaniel
(b) Address: 3018 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/44 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cemetery
Location: Baltimore County, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: North Ave. & Broadway

FEB 21 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH February 18 1944 at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1944 to Feb 18 1944 and that I last saw him alive on Feb 18 1944.

Immediate cause of death: Coronary occlusion — Duration: Sudden

Due to: Coronary sclerosis — ?

Due to: Hypertensive cardio-vascular disease — 10-15 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: N. V. Harbold M.D.
Address 4706 Harford Road Date signed 2/20/44

G 14266 ✓ G 14266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 N. Conklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. Conklin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET ELIZABETH WALPER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1877

8. AGE: Years	Months	Days	If less than one day
66	8	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Walper
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Krause
15. Birthplace Baltimore

16 (a) Informant Mrs. Albert A. Walper
(b) Address 4234 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 FEB 21 1944 (Date rec'd by registrar) (Huntington Williams M.D. Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1944 at 3.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1944, to Feb. 18 1944, and that I last saw h[illegible] alive on Feb. 17 1944.

Immediate cause of death	Duration
myocardial insufficiency	2 days.
Due to cerebral hemorrhage	2 weeks.
Due to hypertension	?
Other Conditions arterio-sclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C. Stitzel M.D.
Address 447 N. Kenwood Ave. Date signed 2/19/44

G 14267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 14267 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins Ave.
(c) Hospital or institution St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Wheeler Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B. Zimmerman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/1887

8. AGE: Years	Months	Days	If less than one day
56	2	16	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Wm Blank
13. Birthplace Md

MOTHER
14. Maiden Name Eva M. Fuller
15. Birthplace Md

16 (a) Informant Wm A Zimmerman
(b) Address 22 Wheeler

17 (a) BURIAL (b) Date thereof 2/23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. B. WIPPERT, SON
(b) Address 850 N. Bellingham Ave

FEB 21 1944 (b) Inserting for Williams, M.D.
(Date received by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1944, at 9 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1944, to 2/20 1944, and that I last saw her alive on 2/20 1944

Immediate cause of death Cardiac Failure — Duration

Due to Diffuse myocardial fibrosis

Due to

Other Conditions ① Diabetes Mellitus ② Emphysema & Gall Bladder
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur Rosberg M.D.
Address St. Agnes Hosp. Date signed 2/20/44

6 14266
448884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

6 14268 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Thames St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Defena Jose Gamallo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Concepcion Gil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day hr.	min.
59	6			

9. Birthplace Spain (Town, county, and state)
10. Usual Occupation candle maker
11. Industry or business

MOTHER / FATHER
12. Name Raymond Gamallo
13. Birthplace Spain
14. Maiden Name Dominga Gamallo
15. Birthplace Spain

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 22/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

FEB 21 1944 (Date rec'd by registrar) Huntington Williams (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1944 at 7 01 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1944 to Feb. 17 1944 and that I last saw him alive on Feb. 19 1944.

Immediate cause of death Cerebral Accident — Duration 3 days

Due to Auricular Fibrillation & resultant Embolic Encephalitis ?? — 5 days ?

Due to Bronchitis (?) TBC ? — 6 months

Other Conditions Peptic Ulcer - Pulmonary Tbc, Diabetes (Include pregnancy within 3 months of death)

Date of operation 2/15/44

Major findings of operation: Peptic ulcer at Pylorus. Pyloric obstruction.

Findings of autopsy: Tbc of Lung & Peritoneal Tbc

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 2/19/44

(over)

14269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

81a

Registered No. 14269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 64
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Moyer Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mc Clelland (BONOLIS)

3 (b) If veteran, name war: NO —

3 (c) Social Security Account No. NONE —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: SINGLE —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) SEPT. 15 1942

8. AGE: Years 1 | Months 5 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name PAUL BONOLIS
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ELLA M. McCELLAND
15. Birthplace BALTO. MD.

16 (a) Informant ELLA M. BONOLIS. (MOTHER)
(b) Address 2107 MOYER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 22/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1944, at 10 45 AM

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Meningitis
undetermined.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Nelson M.D.
Medical Examiner.
Date signed 2-19-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14270 G 14270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 14270

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 Longwood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Longwood St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Filman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state or foreign country)

10. Usual Occupation Grocery Store

11. Industry or business

FATHER
12. Name Daniel
13. Birthplace Russia

MOTHER
14. Maiden Name Dora
15. Birthplace Russia

16 (a) Informant Aaron Filman
(b) Address 1802 Longwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Beth Hillel
Location Wyman Park Rd

18 (a) Funeral director Jas C Levin Inc
(b) Address 1439 E. Balto St

FEB 21 1944 (Date rec'd by registrar) (b) Huntington Williamsburg, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1944 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1944 to 2-19 1944 and that I last saw him alive on 2-19 1944.

Immediate cause of death Coronary Thrombosis
Cln. card. vas. disease — Duration 5 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Edmund Levin

Address 3400 Hilton Rd Date signed 2/19/44

6 1 4273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

6 1 4273 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Mt. Sinai Home 4613 Park Heights Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Moses Beskin

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day: hr.	min.
81				

9. Birthplace Russia (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Lazarus Beskin
13. Birthplace Russia

MOTHER
14. Maiden Name Tong
15. Birthplace Russia

16 (a) Informant Next Relative
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-44 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Location Wyndon Post Office

18 (a) Funeral director Jas. Levi Linn
(b) Address 1439 E. Balto St

19 (Date received by registrar) FEB 21 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1944, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1944, to 2-20 1944, and that I last saw h alive on 2-20 1944.

Immediate cause of death: Respiratory failure — Duration

Due to pulmonary edema

Due to Peritonitis (?)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb. 15 1944

Major findings of operation: Volvulus of sigmoid; adhesions

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron J. Myers M. D.
Address Sinai Hospital, Baltimore Date signed 2-28-44

14272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

Registered No. 6 14272

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and name town)
(d) Street No. 1502 E. Federal Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME Amelia K. Lang

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 1900

8. AGE: Years 43 | Months 8 | Days 11 | If less than one day hr. min

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name David Lang

13. Birthplace Germany

MOTHER 14. Maiden Name Freda Klotz

15. Birthplace Germany

16 (a) Informant David Lang

(b) Address 1502 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/44 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial

Location Taylor Ave Parkville

18 (a) Funeral director J. Melville Jenkins

(b) Address 2703 Kirk Ave

19 (a) [illegible] Undertaker Williams, U.S.

(Date rec'd by registrar) FEB 21 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1944, at 5:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2-19-44 at 5:30 P. M.

(b) Where did injury occur? 1502 E. Federal Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Found lying in kitchen with gas burner on

23. Signature Robert Li Gratacap M.D. Medical Examiner

Date signed 2-20-44.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1-3273

YA-86537

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Preastman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Dent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1929

8. AGE: Years	Months	Days	If less than one day
14	5	3 6	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Thomas J.
13. Birthplace Md.

MOTHER
14. Maiden Name Sara E. Joyce
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 2/14/44 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Preastman St

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1944, at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1944, to 2/18 1944, and that I last saw h[illegible] alive on 2/18 1944.

Immediate cause of death
Rheumatic C.V.D.
Cardiac decompensation
Due to rheumatic fever (active)

Due to

Other Conditions Hydrothorax
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: Miliary Tuberculosis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Earl R. Kinney M. D.
Address Balt. City Hospitals Date signed 2/18/44

~~#4 21-2544~~ B 1274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. B 1274

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 light St.

(c) Hospital or institution South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 60 W West St. (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Philip Wayne Lindsay

3 (b) If veteran, name war V

3 (c) Social Security Account No. V

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1943

8. AGE: Years | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Philip Lindsay

13. Birthplace Pa.

MOTHER 14. Maiden Name Elizabeth Haynes

15. Birthplace Balto Md

16 (a) Informant Mrs Elizabeth Lindsay

(b) Address 60 W. West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23, 1944 (month) (day) (year)

(c) Cemetery or crematory Dodge Cross

Location Ga Ext

18 (a) Funeral director A. C. Howard & Sons

(b) Address 1400 S. Charles

FEB 21 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 1944, at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1944 to 2-20 1944 and that I last saw him alive on 2-20 1944.

Immediate cause of death: Bilateral pneumonia — Duration 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles R. Woodland M.D.

Address 1213 Light St Date signed 2-20-44

PHYSICIAN

Underline the cause to which death should be charged statistically

H. Wollammeber M.D. asst Med Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 12275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

6 12275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cranberry Station
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma E. Hull

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Amanda Hull
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Leander Hull
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Fotrabaugh
15. Birthplace Maryland

16 (a) Informant Univ. Hospital Report
(b) Address Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 24 44 (month) (day) (year)
(c) Cemetery or crematory Union
Location Westminster R. D.

18 (a) Funeral director D. E. Myers & Son
(b) Address Westminster

(a) Date received (month, day, year) 2-24-1944 (b) Huntington Williamsport Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1944 at 4.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7, 1944 to Feb 21 1944
and that I last saw him alive on Feb 21, 1944

Immediate cause of death Respiratory failure — Duration 2 days

Due to Uremia

Due to Postoperative - Carcinoma of prostate gland

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/2/44

Major findings of operations Carcinoma suprapubic prostate gland.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred T. Nelson M. D.
Address University Hospital Date signed 2/24/44

G 14276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14276 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Gough Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Walter Borowiak

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-[illegible]

8. AGE: Years	Months	Days	If less than one day: hr.	min.
41				

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lawrence Borowiak
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Penkowski
15. Birthplace Poland

16 (a) Informant Mary Borowiak
(b) Address 1817 Gough st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Oppenheimer
(b) Address 1930 Eastern Ave

19 (a) 2 1944 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1944, at 8 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Thrombosis of Coronary Venous Sinus.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

23. Signature Howard J. Mullen M.D.
Medical Examiner
Date signed 2-19-44

VS 181

PRINTED WITH PERMANENT, BLACK CARBON INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 14277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6 14277

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 40 S. Ellwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a State Md. b County

c City or town Baltimore (If outside city or town limits, write RURAL and give town)

d Street No. 40 S. Ellwood Ave. (If rural, give location)

e Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Frances Ciesiik

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John Ciesiik

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day: hr. min

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER 12. Name Adam Brzozowski

FATHER 13. Birthplace Poland

MOTHER 14. Maiden Name Monk

MOTHER 15. Birthplace Poland

16 (a) Informant Walter Ciesiik

(b) Address 2528 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17 44 (month) (day) (year)

(c) Cemetery or crematory Holy Sepulchre

Location Baltimore

18 (a) Funeral director Fred W. Oxenham

(b) Address 1930 Eastern Ave

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1944, at 12:9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 14 1944 to Feby 18 1944 and that I last saw h[illegible] alive on Feb 18 1944

Immediate cause of death Cardio Respiratory Paralysis — Duration: 4 days

Due to Hemiplegia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. V. Clift

Address 5010 Greenleaf Road Date signed 2-19-44

1-4278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

6 1-4278

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2535 Emerson St.

(c) Hospital or institution:

Bon Secours Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 weeks

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2535 Emerson St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Wallace Overton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1943

8. AGE: Years | Months 1 | Days 2027 | If less than one day hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Wallace S. Overton

13. Birthplace Fleeton, Va.

MOTHER 14. Maiden Name Margaret Harris

15. Birthplace Baltimore, Md.

16 (a) Informant Wallace S. Overton

(b) Address 2535 Emerson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-44 (month) (day) (year)

(c) Cemetery or crematory Westerns

Location Baltimore

18 (a) Funeral director Frederick L. Cole

(b) Address 1200 W. Lombard St

19 (c) FEB 21 1944 (Date received by registrar) Huntington Williams Asst

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1944 at 8:45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 2-6 1944 to 2-19 1944 and that I last saw h live on 2-19 1944.

Immediate cause of death	Duration
Terminal Broncho-Pneumonia	1 Week
Due to Malnutrition & dehydration	7 weeks
Due to Pyloric Stenosis	?
Other Conditions	

(Include pregnancy within three months of death)

Date of operation 2/8/44

Major findings of operation: Same

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify which)

(e) Means of injury

23. Signature Edward L. D. Krieg MD

Address Bon Secours Hosp Date signed 2/29/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1279

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 D

Registered No. 1279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 E Gross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 E. CROSS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** MARIA SCHLEEF

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	MARRIED

6 (b) Name of husband or wife HENRY SCHLEEF
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL-19-1871

8. AGE: Years	Months	Days	If less than one day
72	10	0	hr. min.

9. Birthplace GERMANY. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business —

FATHER
12. Name NOT KNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY.

16 (a) Informant HENRY SCHLEEF.
(b) Address 226 E CROSS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-22-44 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS.
Location A A Co

18 (a) Funeral director Bernard C Hart
(b) Address 121 E West St

FEB 21 1944 (Date rec'd by Registrar) (b) Huntington Williams (Registrar)

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 19 1944 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1944 to Feb 19 1944 and that I last saw h[illegible] alive on Feb 18 1944.

Immediate cause of death Myocardial Insufficiency — Duration

Due to

Due to

Other Conditions Arterio sclerosis & Myocarditis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schmuck M. D.
Address 1337 S. Charles St Date signed 2/21/44

G 1.2280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 1.2280
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Dorsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1863

8. AGE: Years 81 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Charles Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace —

16 (a) Informant Mrs Margaret M. Penn
(b) Address 1006 N. Mount St.

17 (a) Burial (b) Date thereof 2-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem
Location Balto. Co. Md.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) FEB 21 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1944, at 11:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerosis Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 2-19-44

A certificate which is incomplete, illegible, or unsatisfactory in any particular will be returned for correction. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14281

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna A. Huster

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single~~, ~~married~~, ~~widowed~~, or divorced: Widowed
6 (b) Name of husband ~~or wife~~: Robert Huster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10th 1899

8. AGE: Years 45 | Months 1 | Days 7 | If less than one day: hr. min.

9. Birthplace Bronx N.Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Julius Greenhut
13. Birthplace N.Y.

MOTHER
14. Maiden Name Lillian Anna (Unknown)
15. Birthplace N.Y.

16 (a) Informant Lillian M. Huster
(b) Address 1028 N. Fulton Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Mary
Location Manchester

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1944 at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an enquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner
Date signed 2-18-44

VS 151

1-1282

BALTIMORE CITY HEALTH DEPARTMENT — V — G 1-1282

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 901 E 30th

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 M

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 901 E 30th St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Woodard

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thornton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 21 1892

8. AGE: Years 51 | Months 5 | Days 28 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business:

FATHER — 12. Name: Thomas Rupp

13. Birthplace: Balt Md

MOTHER — 14. Maiden Name: Mary Reilly

15. Birthplace: Balt Md

16 (a) Informant: Thornton Woodard

(b) Address: 901 E 30th St

17 (a) Burial: (Burial, cremation, or removal) (b) Date thereof: 2/22/44 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park

Location: Baltimore Md

18 (a) Funeral director: Wilson Bros Inc

(b) Address: 1217 E Baltimore St

19 Filed: FEB 21 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1944 at 3 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to Feb 18 1944 and that I last saw him alive on Feb 17 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 2/16/44

Due to: Arteriosclerosis — 1/1/1942

Due to: Ch. Myocarditis — 1/1943

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: William J Roark Jr M. D.

Address: 701 W Lexington St Date signed: 2/20/44

VS 180

6 14283 ✓ 6 14283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 840 Hampson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 Hampson St
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Ethel W. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Norfolk Va

8. AGE: Years 39 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Norfolk Va (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Chester Williams
13. Birthplace Norfolk Va

MOTHER
14. Maiden Name Nora Williams
15. Birthplace Norfolk Va

16 (a) Informant Ruth Watkins
(b) Address 840 Hampson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaac C Brown Son
(b) Address 1080 Montgomery St

19 (a) (Date received by Registrar) Huntington Williams M.D. Registrar

FEB 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1944 to 2/16 1944.
and that I last saw her alive on 2/14 1944

Immediate cause of death
Lobar Pneumonia

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature B W Heath M. D.
Address 2134 Druid Hill Ave Date signed 2/20/44

G 14284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 82B

G 14284 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: Mainwaring Hospital, Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 N. Baltimore, Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Holtgrieve

3 (b) If veteran, name war	3 (c) Social Security Account No.
~	~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Late Louis Holtgrieve
6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) March 11, 1879

8. AGE: Years	Months	Days	If less than one day
64	11	9	____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name John Sohl
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Catherine Englehardt
(b) Address 617 Wayne Ave Silver Spring

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Longwood & Edmondson Ave

18 (a) Funeral director John F. Cowan & Son
(b) Address 1403 Hollins St.

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) Waiting for Interment Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1944 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1944 to 2-20 1944. and that I last saw her alive on 2-19 1944.

Immediate cause of death	Duration
Cerebral embolism	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. L. Ingram M. D.
Address Mainwaring Hospital Baltimore, Md. Date signed 2-20-44

VS 3

G 14285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 14285

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 W. Lanvale St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 W. Lanvale St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henrietta Sipes

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23 1867

8. AGE: Years 76 | Months 4 | Days 28 27 | If less than one day hr. min.

9. Birthplace Randallstown Md (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Ephraim C. Sipes
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Grygole
15. Birthplace Baltimore Md.

16 (a) Informant Lillie Moss
(b) Address 1927 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olive Cem Loch Raven Md.
Location Loch Raven, Md.

18 (a) Funeral director John Howard Cox
(b) Address 901 03 Baltimore Street

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1944 at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Feb 20 1944 and that I last saw h e alive on Feb 20 1944.

Immediate cause of death Pulmonary Tuberculosis
Due to Acute C Heart Dilat
Due to —
Other Conditions Renal Calculi
(Include pregnancy within 3 months of death)

Duration 3 yrs

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address [illegible] Date signed

VS 150

4286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 6 2 4286

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 746 Penna. Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 746 Penna. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rosetta

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1899

8. AGE: Years 44 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Shipyard

FATHER
12. Name ?
13. Birthplace Georgia

MOTHER
14. Maiden Name Lizzie Hall
15. Birthplace Ga.

16 (a) Informant Rosetta Hall
(b) Address 746 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Odolaya Valsted
(b) Address 918 Druid Hill Ave.

19 FEB 21 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1944, to 2/18 1944, and that I last saw h alive on 2/18 1944.

Immediate cause of death
Hypertension Cardio-Renal-Vascular

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 3 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Hatcher M. D.
Address 1 r R St. N.W. Date signed 2/24/44

14287

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 14287

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Frederick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside either town limits, write RURAL and give town)
(d) Street No. 434 S. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L Downs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Michael Downs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12. 1870

8. AGE: Years 74 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Casey
FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name
MOTHER 15. Birthplace Ireland

16 (a) Informant Margarite Cross
(b) Address 2230 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22. 44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Frederick Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore St.

19 (a) FEB 21 1944 (Date of death) (b) Huntington for Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1944 to Feb 19 1944, and that I last saw h[illegible] alive on Feb 19 1944.

Immediate cause of death: Acute dilatation of Cardio Vascular System
Hemiplegia

Due to

Due to

Other Conditions Coronary Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C Cross M.D.
Address 451 Wilson St Date signed 2/21/44

14288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 14288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2030 Wilkens Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo 7 dys

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Mc Henry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janet (Jeanette) Roberta Nash

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Infant

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 13-1943

8. AGE: Years	Months	Days	If less than one day
0	3	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Robert J Nash
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Beryl Nupp
15. Birthplace Pa

16 (a) Informant Mrs. Beryl Nupp
(b) Address 1510 Mc Henry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22-44 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Balto. Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hollins St

19 (a) Date received by registrar FEB 21 1944 (b) Registrar Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1944, at 10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute intestinal pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb 20 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

89 / 61

Registered No. 6 14289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 315-S. Duncan St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (3)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315-S. Duncan St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? 40 years

3 (a) FULL NAME Katarzyna Murawski KATARZYNA MURAWSKI

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife John Murawski
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Warsaw, Poland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER 12. Name Kaczkowske
13. Birthplace Poland
MOTHER 14. Maiden Name not known
15. Birthplace Poland

16 (a) Informant Mrs. John Murawski
(b) Address 315-S-Duncan St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County
18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street
(a) FEB 21 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 19 44 at 8.9 M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1943 to Feb 18 19 44 and that I last saw h alive on Feb 14 1944.

Immediate cause of death Diabetes — Duration 3 yrs 20
Due to
Due to
Other Conditions Hypertension — 5 yrs
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lorcan Greenan M. D.
Address 2436 Maryland Ave Date signed 2-19-44

R C CROSS —

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

b 1290 (2)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310 b 1290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3214 Dudley Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3214 Dudley Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charles V. Mettee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband of wife Helen M. nee Preller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5-1881

8. AGE: Years	Months	Days	If less than one day
62	10	14	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Frankford Dist

FATHER — 12. Name Joseph Mettee

13. Birthplace ?

MOTHER — 14. Maiden Name Catherine ?

15. Birthplace ?

16 (a) Informant Helen M. Mettee

(b) Address 3214 Dudley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2- -44 (month) (day) (year)

(c) Cemetery or crematory Morland

Location Baltimore

18 (a) Funeral director Leonard J. Keck

(b) Address Harford Road

FEB 21 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1943, to Feb 19 1944, and that I last saw alive on 19

Immediate cause of death Coronary Occlusion

Due to Hypertension Cardiac Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 1 day years

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Geo. A. Bayley, M.D.

Address Charles & Biddle Sts. Date signed 2/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 1291 (1) AB-86217

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G 1291 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Crofoot

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27-1903

8. AGE: Years	Months	Days	If less than one day
40	10	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER: 12. Name George Crofoot
13. Birthplace Md.

MOTHER: 14. Maiden Name Laura Beal
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory ~~Loudon Park~~
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

FEB 21 1944 Date rec'd by Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20/44 19 , at 8 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/28/44 19 to 2/20/44 19 , and that I last saw h~~im~~ alive on 2/20/44 19 .

Immediate cause of death Pulmonary T.B.c — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Not done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl R. Kinney M. D.
Address Balt. City Hospitals Date signed 2/20/44

6 14292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

Registered No. 6 14292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Harford Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius B. Donat

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	divorced

6 (b) Name of husband or wife Maria E. Donat

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31 1891

8. AGE: Years	Months	Days	If less than one day
53 54	-	18	hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation Plumbing

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Larder
(b) Address Wilson Line

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 2305 Harford Rd.

19 FEB 21 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1944 at 3:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Dislocation of 3rd cervical vertebra

Due to

Other Conditions Acute alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-19-44 at 2 P. M. 9/9
(b) Where did injury occur? 1803 Harford Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Fell down the stairs.

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 2-19-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

1293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

6 1293 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2715 Christopher Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 Christopher Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wade Ed. Mc Cubbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Addie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 - 1884

8. AGE: Years	Months	Days	If less than one day
59	7	13	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Conductor

11. Industry or business Penna R. R.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Addie M. Mc Cubbin
(b) Address 2715 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/44 (month) (day) (year)

(c) Cemetery or crematory New Freedom
Location New Freedom - Pa.

18 (a) Funeral director Leonard J. Rusk
(b) Address 5325 Harford Road

FEB 21 1944 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1944 at 5-20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 42 to Feb 18 1944 and that I last saw him alive on Feb 18 19 44.

Immediate cause of death Cardiac Decompensation (CORD) — Duration 7

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Shimanek M.D.
Address 3711 Ballard Date signed 2-18-44

SHIMANEK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 6 1294

6 1294

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1404 Clarkson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1404 Clarkson St
(If outside city, or town limits, write RURAL and give town)
(d) Street No. Davis Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T. Baker.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Lena M. Hauck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/1869

8. AGE: Years	Months	Days	If less than one day
74	10	7	hr. min.

9. Birthplace Davis Md.
(Town, county, and state)
10. Usual Occupation Ret. City Employee
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 1404 Clarkson St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 2-22-44 (month) (day), (year)
(c) Cemetery or crematory Western Cem.
Location Edgewood Ave.

18 (a) Funeral director Jas. L. McCauley
(b) Address 1210 E. Fort Ave.

19 (a) 2-21-1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1944 at 9 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 18th 1944 to Feby 18 1944
and that I last saw h[illegible] alive on 2-18- 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	7 hrs
Due to Arteriosclerosis	
Due to 74 yrs	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas H. Magruder M.D.
Address 4 E. Read St Date signed 2/20. 44

— 2 — 7 Reg. 2689 —

B 14295 — BALTIMORE CITY HEALTH DEPARTMENT — B 14295 Registered No.

CERTIFICATE OF DEATH 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 N Castle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 14
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 N Castle (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Kratz

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Marie Kratz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 - 1890

8. AGE: Years 53 | Months 1 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Produce Business
11. Industry or business

FATHER 12. Name Wm Kratz
13. Birthplace Baltimore

MOTHER 14. Maiden Name Dont Know
15. Birthplace Baltimore

16 (a) Informant Mrs Wm Rookes
(b) Address 935 N Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/44 (month) (day) (year)
(c) Cemetery or crematory Mayland Memo. Park
Location Parkville Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) FEB 21 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 20 1944, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1941 to Feb 20 1944, and that I last saw h. alive on Feb 18 1944.

	Duration
Immediate cause of death: Coronary Thrombosis	2
Due to: Coronary artery Disease	1 year
Due to:	
Other Conditions: Myasthenia gravis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Brill M. D.
Address 826 N. Washington St Date signed 2/20/44

6 14296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

6 14296 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3203 Ramona Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Ramona (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilhelmina Fink

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1873

8. AGE: Years 70 | Months 7 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm Fink
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Burst
15. Birthplace Germany

16 (a) Informant Wm Fink
(b) Address 3216 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md.

18 (a) Funeral director Ulman Funeral Home
(b) Address 2001 Orleans St

19 (a) FEB 21 1944 (Date received by local registrar) (b) Livingston Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11- 1943 to 2-19- 1944, and that I last saw him alive on 2-19- 1944.

Immediate cause of death	Duration
Paralysis Agitans	14 yrs.
Due to: Generalised arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang M. D.
Address 2117 Belair Rd Date signed 2-21-44

6 14297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 14297 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 Clay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 Clay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis C. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1887

8. AGE: Years 57 | Months - | Days 26 | If less than one day: hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Henderson
13. Birthplace Gloucester England

MOTHER
14. Maiden Name Ann Braine
15. Birthplace Gloucester England

16 (a) Informant Alice Hall (Daughter)
(b) Address 1037 Clay Street

17 (a) Burial (b) Date thereof Feb. 22 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie P. Williams
(b) Address 3229 W. Belvedere Ave.
Huntington Williams, M.D.

19 (a) FEB 21 1944 Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1944, at 7 A. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobar

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 2-18-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 1298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 1298

Registered No. 1006

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Eggleston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Bishop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Allie Bishop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1880

8. AGE: Years	Months	Days	If less than one day
63	2		hr. min.

9. Birthplace Salisbury Md. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Bishop
13. Birthplace Salisbury Md

MOTHER
14. Maiden Name Sarah Porter
15. Birthplace Salisbury Md.

16 (a) Informant Clarence Bishop
(b) Address 847 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem
Location

18 (a) Funeral director Mrs Katie L. Williams
(b) Address 2229 N. Schroeder St.

19 (a) 1 1944 (b) [illegible] for Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1944, at 1A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic phlebitis, bilateral.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
By means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 2-18-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 14299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

6 14299 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 Harlem Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria Stewart

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1924

8. AGE: Years	Months	Days	If less than one day: hr.	min.
19	4	14		

9. Birthplace Md (Town, county and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Charles Stewart
13. Birthplace Petersburg Va.

MOTHER
14. Maiden Name Clara Foxley
15. Birthplace Winfield W. Va.

16 (a) Informant Charles Stewart
(b) Address 1922 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Kate P. Williams
(b) Address 622 N. Eutaw St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 21 1944

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1944 at 7 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1944 to 2/18 1944 and that I last saw h[illegible] alive on 2/18 1944.

Immediate cause of death
Pneumonia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Yes or No)
(e) Means of injury

23. Signature Wm. Kirkendall M.D.
Address 601 N. Calhoun Date signed 2/19/44

42 186

14300

BALTIMORE CITY HEALTH DEPARTMENT X 159

CERTIFICATE OF DEATH

B 14300 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Turner Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Oak Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Baby [illegible] Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1944

8. AGE: Years	Months	Days	If less than one day
			16 hr. 42 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James Walker
13. Birthplace Virginia

MOTHER
14. Maiden Name Jacqueline Flowers
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL FEB 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 21 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1944, at 8:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1944 to Feb. 12 1944, and that I last saw him alive on Feb. 12 1944.

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No significant findings

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stephan, Jr. M. D.
Address Johns Hopkins Hospital Date signed 2-15-44

0745

1-4301 A33980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B 1-4301 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil,
(c) City or town North East.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Blomquist

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-1-1944

8. AGE: Years	Months	Days	If less than one day
		3 4	hr min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Blomquist
13. Birthplace ?

MOTHER
14. Maiden Name Helen Masa
15. Birthplace N.Y.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory JOHN HOPKINS MEDICAL SCHOOL FEB 21 1944
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) FEB 21 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5- 1944 at 5.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 19 44 to Feb. 5 19 44 and that I last saw h alive on Feb. 5 19 44

Immediate cause of death Heart failure — Duration 2 days

Due to Congenital malformation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kapp M.D.
Address J. H. H. Date signed 2-7-44

0743

1-302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 1-302
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County St. Mary's
(c) City or town Mechanicsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Quade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 28, 1944

8. AGE: Years	Months	Days	If less than one day
			3 hr. 52 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Horace Quade
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Fora
15. Birthplace Maryland.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location JOHNS HOPKINS MEDICAL SCHOOL FEB 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1944, at 10.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1944, to Jan. 28 1944, and that I last saw him alive on Jan. 28 1944.

Immediate cause of death Intrauterine asphyxia — Duration
Prematurity
Due to Maternal: Placenta praevia; Antepartum hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stephe Jr. M.D.
Address Johns Hopkins Hospital Date signed 2-1-44

F 0744

6 14303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 14303 Registered No. 50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 N. Calhoun St
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 305 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Letitia Watkins

3 (b) If veteran, name war
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	M

6 (b) Name of husband or wife Jas Watkins
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Oct. 3 - 1898

8. AGE: Years	Months	Days	If less than one day
45 46	4	14	— hr. — min.

9. Birthplace Northumberland Co Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Isaac Armstrong
13. Birthplace Northumberland Co Va

MOTHER
14. Maiden Name Fannie Haynie
15. Birthplace Northumberland Co

16 (a) Informant Jas W. Watkins
(b) Address 305 N. Calhoun

17 (a) Burial (b) Date thereof Feb. 19, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Maryland

18 (a) Funeral director Wood & Holland
(b) Address 631 N. Eutaw St.

19 (a) (b)
(Signature of Registrar) Registrar

FEB 21 1944

Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1943 to Feb 17 1944
and that I last saw [illegible] alive on Feb 16 1944

Immediate cause of death Coma
Pneumonia, Lobar Consolidation
Hypostatic Congestion
Myocarditis, Chronic Interstitial
Spine, well

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
4 Mos.
17 Dy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. F. Hatcher
Address 1 W. Pratt Date signed 2/20/44

G 1+304 GOUKER G 1+304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave + Markland St
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 N. Monroe St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Clara Rebecca Gouker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Wm. D. Gouker
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Oct 9, 1899

8. AGE: Years	Months	Days	If less than one day
44	4	11	..... hr. ..... min.

9. Birthplace Frederick, Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Joseph D. Zimmerman
13. Birthplace Frederick Co., Md

MOTHER
14. Maiden Name Annie Summers
15. Birthplace Frederick Co. Md.

16 (a) Informant William Gouker
(b) Address 1708 N. Monroe St. Balto Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Md.

18 (a) Funeral director M. R. Etchison
(b) Address Frederick Md.

19 (a) FEB 21 1944 (Date received by registrar) (b) Filed by Wm. H. Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1944, at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1944 to Feb 20 1944 and that I last saw h e r alive on Feb 20 1944.

Immediate cause of death	Cerebral hemorrhage	Duration
Due to	embolism rheumatic heart disease	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Wm. H. Williams M. D.
Address West Baltimore General Hospital Date signed Feb 21, 1944

(Over)

6 1305 | BALTIMORE CITY HEALTH DEPARTMENT | 6 1305
CERTIFICATE OF DEATH | Registered No. 184

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 w. 0 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Navy Base Port Covington (If rural give location)
(e) Citizen of foreign country? Single (Yes or No) If yes, name country

3 (a) FULL NAME Thomas N. Cole

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?, 1919

8. AGE: Years	Months	Days	If less than one day
25 24			hr. min.

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation Gun crew
11. Industry or business Navy

FATHER
12. Name C. C. Cole
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant South Baltimore General Hospital Records
(b) Address Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory Mishnaletwa Cem. Location Missouri

18 (a) Funeral director William M. Mareck
(b) Address 715 Light St

FEB 21 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1944, at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wounds of abdomen and chest
Due to Perforating wounds by shell
(Cancel)
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-17-44 at 24 P.M.
(b) Where did injury occur? Pier 5, Port Covington
(c) Did injury occur at home, on farm, industrial place, in public place? Work While at work? Yes.
(d) Means of injury Shot with revolver.

23. Signature H. J. Wollamsen M.D. Official Examiner.
Date signed 2-18-44

6 14306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

6 14306

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 W Fayette Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME EDGAR PARKER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 9, 1902

8. AGE: Years	Months	Days	If less than one day
41	10	12	..... hr. ..... min.

9. Birthplace Piedmont, S.C.
(Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Railroad Shipbuilding

FATHER
12. Name Guy Parker
13. Birthplace S.C.

MOTHER
14. Maiden Name Fannie Black
15. Birthplace S.C.

16 (a) Informant .....
(b) Address .....

17 (a) Removal (b) Date thereof 2/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location Greenville, S.C.

18 (a) Funeral director Wm. J. Dickens & Son
(b) Address North Penna. Ave.

19 (a) Date received by registrar 2-24-44 (b) [illegible]
(Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1944 at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....
Syphilis cardiovascular
due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 2-21-44

4493 36 1-307 BALTIMORE CITY HEALTH DEPARTMENT 6 1-307

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Lutherville (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Nash Iglehart

3 (b) If veteran, name war World War I

3 (c) Social Security Account No. 212-01-3575

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lucy J. Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1-81

8. AGE: Years	Months	Days	If less than one day
62	6	20	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Charles Iglehart
13. Birthplace Annapolis Md

MOTHER
14. Maiden Name Anne Calhoun Robinson
15. Birthplace Balto Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23 44 (month) (day) (year)
(c) Cemetery or crematory St Thomas'
Location Garrison Forest Md

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (b) Practitioner for Williams, M.D. Registrar
Date rec'd by registrar FEB 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1944 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1942 to Feb 21 1944, and that I last saw him alive on Feb 21 1944.

Immediate cause of death: Arterio-sclerotic Heart disease — Duration 1 yr.
Due to
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warder B. Allen M.D.
Address 6 E. Eager St Date signed 2/24/44

FEB 24 1944

B14308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

B14308 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Cloverhill Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs 4mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3907 Cloverhill Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA KEARNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife THOS. KEARNEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 29, 1850

8. AGE: Years	Months	Days	If less than one day
93	7	16	hr. min.

9. Birthplace READING, PA (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Reilly Kearney
13. Birthplace Ireland

MOTHER 14. Maiden Name Annie Faughnan
15. Birthplace Ireland.

16 (a) Informant J Bolton Wimpenny 2nd
(b) Address 3907 Cloverhill Rd Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22-37 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Co

18 (a) Funeral director Henry W. Lemmon
(b) Address 1444 Harlem Ave

FEB 21 1937

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1937, at Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936 to Feb 19 1937, and that I last saw him alive on Feb 18 1937.

Immediate cause of death Myocarditis Arterio-sclerosis — Duration Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. T. Reedy
Address 1403 Park Ave Date signed 2/21/37

[redacted] 130 for G

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14309

1. PLACE OF DEATH: St. Joseph's Hospital
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County *
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2250 Guilford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country *

3 (a) FULL NAME Mrs. Fannie Nolan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John J. Nolan
6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) Dec 21-1868

8. AGE: Years	Months	Days	If less than one day
75	4	28	hr. min.

9. Birthplace Ellicott City-Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Gerhardt Marischen
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Clavercharn
15. Birthplace Germany

16 (a) Informant Loretta Scheve
(b) Address 101 McCormick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director Chas. E. Burns & Son
(b) Address 118 W. Mt Royal Ave

FEB 21 1944 (Date rec'd by registrar) (b) Hunter-Stone Mfg. Photograph

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1944, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27- 1943, to 2-19- 1944, and that I last saw her alive on 2-19- 1944

Immediate cause of death	Duration
Pneumonia	
Due to	
Due to	
Other Conditions Frac. rt. femur	
Arterio- C.V.D.	

(Include pregnancy within 3 months of death)

Date of operation 2-2-44
Major findings of operation: Frac. rt. Femur
Open reduction of rt. femur
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide Acc.
(b) Date of occurrence December 26 1943 M
(c) Where did injury occur? 2250 Guilford Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No (Specify type of place)
(e) Means of injury Fall down stairs at home

23. Signature [illegible] M.D.
Address 1400 N. Caroline St. Date signed 2/19/44

Supplemental: Robert Lee Trautman M.D. 3/8/44
Asst. Med. Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. P. S.—500 Blks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is important. See instructions on back of certificate. Entry

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

6 14310 — 83a — 6 14310

REGISTERED NO.

1—PLACE OF DEATH Preston Apts.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 218 E. Preston ST., WARD)

2—FULL NAME Harold Scarborough

(a) RESIDENCE NO. Preston Apts ST., 11-1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances E. Hinton

6 DATE OF BIRTH (month, day, and year): Nov. 4, 1861

7 AGE — Years: 82 — Months: 3 — Days: 17 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Journalist

(b) General nature of industry, business, or establishment in which employed (or employer): W. S. Hunt.

(c) Name of employer: W. S. Hunt.

9 BIRTHPLACE (city or town) (State or country): Harford County.

PARENTS

10 NAME OF FATHER: Silas Scarborough

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford County

12 MAIDEN NAME OF MOTHER: Catherine Bishop.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Katherine Scarborough.

(Address) Preston Apts

15 FEB 22 1944 19 Huntington Methodist, Md.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-21-44

17 I HEREBY CERTIFY, That I attended deceased from ..., 19 34 to Feb 21, 19 44, that I last saw him alive on Feb. 21, 19 44 and that death occurred, on the date stated above, at 8 15 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & vascular accident.

(duration) 20 yrs. mos. da.

CONTRIBUTORY (Secondary): Broncho-pneumonia no early stage (duration) — yrs. — mos. 1 da.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) John M. Fischer, M. D.

19 (Address) 103 W. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ — DATE OF BURIAL: Darlington Cem — Feb 23 19 44

20 UNDERTAKER — ADDRESS: H. S. Bailey — Darlington Md

12311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6 12311

1312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 56 Bloom
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days) 38

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 56 Bloom
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race Col

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband~~ or wife Annie F. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 19-83

8. AGE: Years 60 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business P. R. R.

FATHER
12. Name George Smith
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Smith
15. Birthplace Va

16 (a) Informant Annie F. Smith
(b) Address 56 Bloom St

17 (a) Burial (b) Date thereof 2-24-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Sam'l M. Chase Wm
(b) Address 638 N. Gilmor St

19 (a) 2-22-1944 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-1944 at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1944 to 2-19-1944 and that I last saw h[illegible] alive on 2/19/1944

Immediate cause of death Cardiac Insufficiency — Duration

Due to Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunt Roberts M. D.

Address 2139 Druid Hill Ave Date signed 2-21-44

VS 189

1-312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

6 1-312 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401. Myrtle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401. Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Truly Henry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Langford Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Va (town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John. Foster
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mamie Henry
(b) Address 1401 Myrtle Ave

17 (a) Burial (b) Date thereof 2-24-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Emmitsburg Md

18 (a) Funeral director Sam'l H. Chase Mrs
(b) Address 638 N. Gilmor St

(a) FEB 22 1944 (b)
(Date Rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 1944 at 3.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1944 to 2/20 1944, and that I last saw h[illegible] alive on 2/19 1944.

Immediate cause of death: Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. J. Stafford
Address [illegible] Md Date signed 2/22/44

No. 14313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 14313

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1952 Annapolis Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1952 Annapolis Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Edna M Long

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Frederick Long

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr) April 13 1894

8. AGE: Years	Months	Days	If less than one day
49	10	5	hr. min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frank J Herr
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Dora P Flack
15. Birthplace Baltimore Md

16 (a) Informant Frederick E Long
(b) Address 1952 Annapolis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 1944 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location City

18 (a) Funeral director Pratt & B M Walter
(b) Address Pratt & Strieker Sts

19 (a) FEB 22 1944 (Date rec'd by Registrar) (b) Flintstone Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1944, at 3 35 M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature — M.D. Medical Examiner.
Date signed 2-17-44

VS 151

1-314

AB-88379

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

6 1-314 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Donahue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1891

8. AGE: Years	Months	Days	If less than one day
52	1	23 22	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bernard Donahue
13. Birthplace Ireland

MOTHER
14. Maiden Name Emma Casey
15. Birthplace Pa

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Roll C & B. M. City Walter

18 (a) Funeral director PRATT & STRICKER Sts
(b) Address

FEB 22 1944 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1944 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1944 to 2-20 1944, and that I last saw h[illegible] alive on 2-20 1944.

Immediate cause of death: Pulmonary TBC — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Paul Hoff M. D.

Address B. C. H Date signed 2-20-44

1x315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

6.1x315 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2204 Cambridge Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Cambridge Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislaw Michael Lewatowski, OR James Michael Lavender)

3 (b) If veteran, name war none

3 (c) Social Security Account No. 216-10-0181

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cecelia

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Oct, 26, 1893

8. AGE: Years 50 | Months 3 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Pittsburge, PA. (Town, county and state)

10. Usual Occupation Machinist, Service Man.

11. Industry or business Owens Ill Can Co.

FATHER
12. Name Andy Lewatowski
13. Birthplace Poland

MOTHER
14. Maiden Name Helen Augustyniak
15. Birthplace Poland

16 (a) Informant Mrs. Cecelia Lewatowski
(b) Address 2204 Cambridge Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-44 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS.
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 So Ann street

19 (a) 2-2-1944 (Date received by registrar) (b) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21st 1944 at 3 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1943 to Feb. 21, 1944 and that I last saw him alive on Feb. 21, 1944

Immediate cause of death: Terminal Bronchial Pneumonia — Duration 2 days

Due to: Pulmonary Tobisis — Duration about 1 year.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature John J Kruger M. D.

Address 2627 Eastern Date signed 2/25/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 250

12316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 12316
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 5
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4908 Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Russell Mays

3 (b) If veteran, name war W
3 (c) Social Security Account No. [illegible]

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband or~~ wife Elnora Mays
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15th 1902

8. AGE: Years 41 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Augusta Co. Va
(Town, county, and state)

10. Usual Occupation Ship-Fitter
11. Industry or business Steel Ships Repairs

FATHER
12. Name Wm. Ruley Mays
13. Birthplace Va

MOTHER
14. Maiden Name Sadie Buchanon
15. Birthplace Va.

16 (a) Informant Wm R. Mays Jr
(b) Address 2803 Rosemont Ave

17 (a) Burial (b) Date thereof 2/23/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto
Location Md

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 22 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1944 at 9 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 PM Feb 20 1944 to 9 PM Feb 20 1944 and that I last saw h[illegible] alive on Feb 20 1944.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Toxemia

Due to Lobar pneumonia

Other Conditions Dehydration Malnutrition
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. R. Gryther M. D.
Address Mercy Hosp Date signed 2/29/44

1431?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. b 1431?

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital. 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mos.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 13 Benhurst Ave Zone 29 (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Dianne DIFFENDERFER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
W	- NONE	Female	White	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo.) April 11 (day) 1938

8. AGE: Years	Months	Days	If less than one day
5	10	10	hr. min.

9. Birthplace York Pennsylvania (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Ralph E. Diffenderfer

13. Birthplace Delaware

MOTHER 14. Maiden Name Velma Folkenroth

15. Birthplace Pa.

16 (a) Informant Ralph E. Diffenderfer

(b) Address 13 Benhurst Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Rose

Location York Pa.

18 (a) Funeral director William Cook Sec

(b) Address 1217 St. Paul St

19 FEB 22 1944 (Date rec'd by registrar) Hunting for Tombaille, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1944 at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1944 to Feb 21, 1944 and that I last saw h alive on Feb 20, 1944.

Immediate cause of death Resp. Failure. — Duration

Due to Lung metastases

Due to Wilms tumor

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1942

Major findings of operation: Wilms tumor of rt kidney

of autopsy: Lung metastases.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Murray Sener M.D.

Address Sinai Hosp. Date signed 2/21/44

VS 180

6 1318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMAIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Kenyon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Kenyon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Ellis Weismon

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1880

8. AGE: Years 64 | Months | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state or foreign country)

10. Usual Occupation Stationary Fireman

11. Industry or business

MOTHER / FATHER
12. Name Frank Weismon
13. Birthplace Md
14. Maiden Name Ambrosius Koch
15. Birthplace Md

16 (a) Informant Harold L Weismon
(b) Address 3004 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Milton Co Inc
(b) Address 1219 E Lombard St

19 (a) FEB 22 1944 (Date rec'd by registrar) (b) Huntington Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1943 to Feb 22 1944, and that I last saw h[illegible] alive on Feb 20 1944

Immediate cause of death: Cerebral Hemorrhage

Due to Arterio Sclerosis Hypertension

Due to

Other Conditions Chronic nephritis Chronic valvular Condition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles A Anderson M. D.
Address 800 Shamrock Ave Date signed Feb 21 44

VS 180

1-319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154

G 1-319 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Pilot Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Phillip Russell

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Dec 12 1943
8. AGE: Years | Months 2 | Days 9 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Glen Russell
13. Birthplace Charleston W. Va.

MOTHER
14. Maiden Name Viola Lawrence
15. Birthplace Wilmington N.Y.

16 (a) Informant Viola Russell
(b) Address 1208 Pilot Ct - Fairfield
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-44 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
19 (a) FEB 22 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21-44 19 , at 11:30 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 19 44 to 2-21 19 44, and that I last saw him alive on 2-21 19 44.

Immediate cause of death: Malnutrition — Duration: 1 wk

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R. MacDonald
Address 1213 Light St. Date signed 2-24-44 M. D.

14320 — BALTIMORE CITY HEALTH DEPARTMENT — 1190 — b 14320 Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Lamard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Lamard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Barnes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1943

8. AGE: Years [illegible] Months Days 15 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name James A. Barnes
13. Birthplace Baltimore, Md.

MOTHER — 14. Maiden Name Amy Milburn
15. Birthplace Baltimore, Md.

16 (a) Informant James A. Barnes
(b) Address 1204 Lamard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23 1944 (month) (day) (year)
(c) Cemetery or crematory St Peters Cemetery
Location West Baltimore

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St
(Date received by registrar) FEB 22 1944 (Signature of registrar) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20- 1944 at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20-1944 to 2-20-1944 and that I last saw h[illegible] alive on 2-20-1944

Immediate cause of death Infantile Diarrhea — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George E. Page, M.D.
Address 616 N. Mount St Date signed 2-22-44

14321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. 14321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 - N. Caroline St

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 17 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 3257 E. Baltimore St. (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME BABY GIRL DAWSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/44.

8. AGE: Years	Months	Days	If less than one day
		17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Vergal L. Dawson

13. Birthplace Md.

MOTHER — 14. Maiden Name Anna B. Holub

15. Birthplace Md.

16 (a) Informant Vergal L. Dawson

(b) Address 3257 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 22 44 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cem.

Location Hanson Mill Rd. Balto. Co. Md

18 (a) Funeral director Charles J. Feiler

(b) Address 3605 Fait Ave.

19 (c) FEB 22 1944 Huntington Williams, M.D. Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21 1944 at 7:12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5 1944 to 2/21 1944

and that I last saw h alive on 2/21 1944

Immediate cause of death: Infection Hemorrhage

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. B. Ballena M. D.

Address St. Joseph's Hosp. Date signed 2/21/44

B 14322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

B 14322 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 Woodall St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Woodall St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul W. Massicot

3 (b) If veteran, name war —

3 (c) Social Security Account No. 263-28-2269

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lula L. Massicot

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 18-1880

8. AGE: Years 64 | Months 01 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Coca Cola Bottling Co

FATHER
12. Name Robert Massicot
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Appel
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Lula L. Massicot
(b) Address 1412 Woodall St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-22-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Flynn & Flanning
(b) Address 1416 Light St

19 (a) Date received FEB 22 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1944 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1943 to 2-21-1944 and that I last saw h[illegible] alive on 2-20 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Chronic Myocardial Degeneration — Duration 1 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Gallod M. D.
Address 207 E. Fort Ave. Date signed 2-21-44

14323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 6 14323

1316 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 255 W Hoffman St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-H

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 255 Hoffman St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	M.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day hr.	min.
55				

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Mary Thomas

(b) Address 255 Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) FEB 22 1944 (Date received by Registrar) (b) Registrar

VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1944 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1943 to Feb 20 1944 and that I last saw him alive on Feb 20 1944.

Immediate cause of death Edema General — Duration 4 Wks

Due to Nephritis — Duration 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H H Walters M. D.

Address 214 N Gilmor Date signed 2-22-44

1-324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 108

Registered No. 1-324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E O'Donnell

3 (b) If veteran, name war	3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
43			hr. min

9. Birthplace Howard Co. Md. (Town, county, and state)
10. Usual Occupation Shipyard Worker
11. Industry or business

FATHER — 12. Name Thos. R O'Donnell
13. Birthplace Md.

MOTHER — 14. Maiden Name Sarah Brown
15. Birthplace Md.

16 (a) Informant Thomas O'Donnell
(b) Address Catonsville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-44 (month) (day) (year)
(c) Cemetery or crematory St Marks
Location Highland Md

18 (a) Funeral director J C Higinbotham
(b) Address Ellicott City Md

Date received by local registrar FEB 22 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 1944 at 1030 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1944 to 2-20 1944
and that I last saw him alive on 2-20 1944.

Immediate cause of death: Lobar pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar pneumonia

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifton Koshera M.D.
Address St Agnes Hosp Date signed 2/24/44

Correct age is especially important. Physicians: please write the words of death clearly, and be sure to underline the cause to which death should be charged statistically.

B 1325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

B 1325 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609 Springhill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2609 Springhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LIZZIE CHASON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day hr.	min.
62				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name Idy
15. Birthplace Russia

16 (a) Informant Mrs. Wachsman
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) Date received by Registrar 2-22-1944 Huntington Williams M.D. Registrar

FEB 22 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/44 19 at 4.50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1943 to Jan 18 1944, and that I last saw h[illegible] alive on Jan 18 1944

Immediate cause of death Coronary Thrombosis — Duration 18 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Sherry MD

Address 11 E. Chase St Date signed 2/24/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

No. 24326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 326

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12
(c) Hospital or institution: Leumm Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 m
(e) Length of stay in Baltimore (yrs., mos., or days) 4 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] a. (b) County .....
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 W. 33rd St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME IDA. B. STRAUSS

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Jacob Strauss
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years: 61 | Months: | Days: | If less than one day: hr. min

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business: .....

FATHER
12. Name: — Cole
13. Birthplace: Virginia

MOTHER
14. Maiden Name: —
15. Birthplace: Virginia

16 (a) Informant: Mrs. Stein
(b) Address: 3718 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetary
Location .....

18 (a) Funeral director: Jack Levin Inc
(b) Address: 1439 E. Baltimore St

19 (a) FEB 22 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1944, at 3 05 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? .....
(d) Means of injury .....

23. Signature H. L. Wollenmeier M.D.
Medical Examiner.
Date signed 2-21-44

1 Cert

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

V 6 14327 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-1
(c) Hospital or institution: Hosp for the Women of Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22da.
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Monterey Apt. C (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Bertha Levinstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25 1897

8. AGE: Years	Months	Days	If less than one day
47	0	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name ISRAEL
13. Birthplace RUSSIA

MOTHER 14. Maiden Name YETTA
15. Birthplace RUSSIA

16 (a) Informant HOSPT RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-21-44 (month) (day) (year)
(c) Cemetery or crematory WASH. RD
Location SILVER SPRING MD

18 (a) Funeral director Jack Lewis Dr
(b) Address 1439 E Balto St

19 (a) FEB 22 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1944, at 5:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1944 to Feb 21 1944 and that I last saw her alive on Feb 21 1944.

Immediate cause of death	Duration
Respiratory Failure	2 da.
Due to Mechanical Ileus	14 da.
Due to Carcinoma of the Transverse Colon with Metastasis	2 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb. 8, 1944
Major findings of operation: Ca. of Transverse Colon & wide spread Metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William E Edmunds M. D.
Address Womens Hospital Date signed 2-24-44

VS 3

Please write plainly, with pen and ink. Every item on this record must be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6 14328

1328 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Park Heights Ave
(c) Hospital or institution Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Israel Lavenstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day hr	min.
60				

9. Birthplace Russia (town, county, and state)
10. Usual Occupation Shoe Maker
11. Industry or business

MOTHER / FATHER
12. Name Albert
13. Birthplace Russia
14. Maiden Name Gertrude
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Fairview Hall Rd

18 (a) Funeral director Jas L. Levin Inc
(b) Address 1439 E. Balto St

FEB 22 1944 (Date rec'd by registrar) (b) Huntington Willis Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/44 19 at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1944 to 2/20 1944 and that I last saw him alive on 2/20 1944

Immediate cause of death Acute Cardiac failure — Duration

Due to Ch Hypertension

Due to Cerebral Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. H. Hornstein M.D.
Address 733 Argyle St Date signed 2/23/44

6 14329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

Registered No. 6 14329

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 E. Clinton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Radtka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	D

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1894

8. AGE: Years	Months	Days	If less than one day
50	0	11	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Ship Fitter
11. Industry or business

FATHER
12. Name Martin Radtka
13. Birthplace Poland

MOTHER
14. Maiden Name Makus
15. Birthplace Poland

16 (a) Informant Gustava Radtka
(b) Address 209 Doris Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/44 (month) (day) (year)
(c) Cemetery or crematory Schwartzes
Location O'donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) FEB 22 1944 (b) Huntingtown Pittsburgh, Pa.
(Registrar) Registrar
FEB 22 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1944, at 3 45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner

Date signed 2-19-44

Physicians will please fill out this certificate with typewriter or pen. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

6 14330 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution West Balt Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 3112 Belmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kubasco

3 (b) If veteran, name war N
3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1944

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace W. B. G. H.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name John O Kubasco
13. Birthplace Pa

MOTHER 14. Maiden Name Martha Novonty
15. Birthplace Ohio

16 (a) Informant John O Kubasco
(b) Address 3112 Belmont Ave

17 (a) Final (burial, cremation, or removal) (b) Date thereof 2-22-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Feldhorn & Lowe
(b) Address 1217 E Pratt St

19 FEB 22 1944 Washington Williams M.D.
(Registered by)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1944 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1944 to Feb 20 1944, and that I last saw h[illegible] alive on Feb 20 1944

Immediate cause of death Premature Birth (Prematurity)
Due to Fetal Atelectasis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 4 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman M. Chechet M.D.
Address WBGH Date signed 2/21/44.

14331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6 14331 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 E 20th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or [illegible] Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1104 Kingsway Rd
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David A MacLeary

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4 Sex	5 Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Male	Wht	Married	Catherine	years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1869

8. AGE: Years	Months	Days	If less than one day
75	1	13	hr. min.

9. Birthplace Baltimore Md (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant A Ross MacLeary
(b) Address 5209 Walther Blvd

17 (a) Burial (b) Date thereof 2-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director William Cook Inc
(b) Address 1719 E Fort Ave

19 (d) FEB 22 1944 per Huntington for Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1944, at 4:46 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1944 to Feb. 17 1944, and that I last saw alive on Feb. 17 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration 6 mos.
Due to: Laryngeal Tuberculosis — Duration 6 mos.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Granger M. D.
Address 1428 Kingsway Rd Date signed 2-20-44

B 14332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓6

6 14332
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State Md b County
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 1549 Leslie Ave (If rural give location)
e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Gibbs
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Alfred
6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-99

8. AGE: Years	Months	Days	If less than one day
45	-	7	hr min.

9. Birthplace Ga (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Oscar Rucker
13. Birthplace Ga.

MOTHER
14. Maiden Name Rady Gilbert
15. Birthplace Ga.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Balto Co. Md.

18 (a) Funeral director Chas H Alexander
(b) Address 927 N. Mount St.

19 FEB 22 1944 (Date received by local registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1944 at 8 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1944 to Feb 21 1944 and that I last saw her alive on Feb 21 1944

Immediate cause of death Respiratory failure — Duration

Due to Septicemia ? meningococcic 24 hrs.

Due to

Other Conditions Cardiovascular collapse
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M.D.
Address JHH
Date signed 2-24

1335 — BALTIMORE CITY HEALTH DEPARTMENT — 1335

CERTIFICATE OF DEATH

46 B — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 W North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
a State Md — b County
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 3000 W North Ave (If rural give location)
e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Selkow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9. 1884

8. AGE: Years	Months	Days	If less than one day
59	9	12	hr min

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Samuel Selkow
13. Birthplace Russia

MOTHER
14. Maiden Name Mural Schenter
15. Birthplace Russia

16 (a) Informant Fannie Selkow
(b) Address 3000 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Road
Location Windsor Mill Rd H. Y. Men

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) FEB 22 1944 (Date rec'd by registrar) Thos. J. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1944, at 2.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1944 to 2/21 1944, and that I last saw h[illegible] alive on 2/21 1944.

Immediate cause of death
Carcinoma of the Stomach
Due to

Duration
1 yr

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip Sankin
Address 2128 W. North Ave Date signed 2/24/44

17

1449 Glaser

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 1 1337

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Exeter Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Glaser

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1904

8. AGE: Years	Months	Days	If less than one day: hr.	min
40				

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

FATHER
12. Name Adolph Glaser
13. Birthplace Russia

MOTHER
14. Maiden Name Freeda Siskind
15. Birthplace Russia

16 (a) Informant Albert Glaser
(b) Address 3902 Hilton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23/44 (Month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cemetery
Location Hamilton ave

18 (a) Funeral director Sol Levinson & Bro.
(b) Address 1124-26 W Northern

19 (a) FEB 22 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21- 19 44 at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions Hypertrophy & dilatation of heart. Chronic hypertrophic arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellenis M.D.
Medical Examiner
Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 12335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 6 12335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
If rural Street No. 407 N. 23rd Ste (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia Esposito

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-4-1893

8. AGE: Years	Months	Days	If less than one day hr.	min.
51	1	16		

9. Birthplace Balto. Co, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name James Grealy
13. Birthplace Italy

MOTHER
14. Maiden Name Alice Flinn
15. Birthplace Lenna

16 (a) Informant Mr Jos. Esposito
(b) Address 407 N. 23rd Ste.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. -24-44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location O'Donnell Ste Rd

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave

19 (a) (Signature of local registrar) (b) Mrs. Lucy Williams Registrar

FEB 25 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1944 at 9 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1944 to Feb. 20 1944, and that I last saw her alive on Feb 20 1944.

Immediate cause of death: Acute cardiac dilatation — Duration

Due to Hypertensive C. V. disease

Due to

Other Conditions: Endarteritis obliterans-feet
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Wallace M. D.
Address 1400 N. Caroline St Date signed 2/20/44

1944

1336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121

Registered No. 6 1336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Caroline
(c) Hospital or institution:
Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Rosario- Rosario

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Coco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
6 4	10	18	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Michele Coco
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Venera Lafrance
15. Birthplace Italy

16 (a) Informant wife Mary Coco
(b) Address 704 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

19 (a) FEB 22 1944 (Date received by registrar) (b) Limitation for Baltimore

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21 1944, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1944, to 2/21 1944, and that I last saw h[illegible] alive on 2/20 1944.

Immediate cause of death [illegible] — Duration

Due to [illegible]

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed 2/24/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

B 14337
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LINCOLN REIGLE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Sallie Harman Reigle
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 24, ~~1860~~ 1865
8. AGE: Years 78 | Months 10 | Days 27 | If less than one day: hr. min.
9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Ass't. Chief Clerk
11. Industry or business B. & O. R. R.

FATHER
12. Name Jacob Reigle
13. Birthplace Penna.

MOTHER
14. Maiden Name Sarah Johnson
15. Birthplace Penna.

16 (a) Informant Mrs. Sallie H. Reigle
(b) Address 2102 Mt. Holly St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cem.
Location Shippensburg, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19. Date received FEB 22 1944 (Month) (day) (year)
(Huntington Williams, M.D.) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1944 at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17, 1944 to Feb 21 1944, and that I last saw h.m alive on Feb 20, 1944.

Immediate cause of death: Bronchial Pneumonia (Bilateral)
Due to
Due to
Other Conditions Paralysis Agitans.
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hope E. Shannon M.D.
Address 820 Medical Arts Bldg Date signed 2/22/44
M. D.

(over)

b 14338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. b 14338

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1945 W Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1945 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stansbury Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex m

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Annie Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1895

8. AGE: Years 849 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Peter Jones
13. Birthplace md

MOTHER
14. Maiden Name Carrie ?
15. Birthplace md

16 (a) Informant Annie Jones
(b) Address 1945 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Eastern Shore
Location Md

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pressman St

19 (a) FEB 22 1944 (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1944, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1944 to Feb 19 1944 and that I last saw h[illegible] alive on Feb 19 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 3 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kelson M. D.

Address 1303 Pressman St Date signed 2/22/44

Please write plainly, with unfading ink. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. B 14339

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 784 E. 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sheppard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1920

8. AGE: Years	Months	Days	If less than one day
23 24	8	17	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James Sheppard

13. Birthplace Md.

MOTHER 14. Maiden Name Maggie Sheppard

15. Birthplace Va.

16 (a) Informant Maggie Sheppard

(b) Address 784 E 28th St

17 (a) Burial (b) Date thereof 2/23/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy Wilson

(b) Address 1600 Brandley Ave

FEB 22 1944

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18-1944, at Wilmington M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound of thigh involving external iliac artery.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-18-44 at 9.55 P. M.
(b) Where did injury occur? Howard & 23½ St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Bullet wound

23. Signature Howard J. Woolley M.D.
Medical Examiner.

Date signed 2-19-44

14340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

C 14340
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 6 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1878

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65				

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ruth Vaughn
(b) Address 404 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley Ave

19 Filed FEB 22 1944 (b) (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1944, at 10:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Pris death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic myocardial degeneration

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed February 17, 1944

14391

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

Registered No. 6 14341

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Provident Hospital 9-H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 784 E 28 St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Daniel Sheppard

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 213-05-4052

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife Hazel Sheppard
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 6 1912

8. AGE: Years	Months	Days	If less than one day
31 32	7	2	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Junius Sheppard
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Wales
15. Birthplace Va.

16 (a) Informant Hazel Sheppard (wife)
(b) Address 2905 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location .....

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Bradley Ave

19 (a) FEB 22 1944 (Date rec'd by registrar) (b) Huntington Tittle (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18-1944, at 9:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun shot wound of chest involving lungs

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-18-44 at 9:55 P.M.
(b) Where did injury occur? Home 2323 St. Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Bullet wound

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 2-19-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1342 / 1119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2416 E. Madison Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD V. LONG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) NOV. 21 1944

8. AGE: Years | Months: 3 | Days: 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward V Long Jr.
13. Birthplace Balto Md

MOTHER
14. Maiden Name Francis Poggi
15. Birthplace Balto Md

16 (a) Informant MOTHER Mrs Edw Long
(b) Address 1519 N. Washington St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-23-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4500 Belair Rd

18 (a) Funeral director Harry Witzke
(b) Address 4101 Edmondson Ave

19 (a) [illegible] Williams M.D.
FEB 22 1944 Huntington
(Registrar's signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1944, at 5:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Diarrhea, infantile

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 2-21-44

14343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. B 14343

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4706 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-14
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4706 Roland Avenue (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Annie Carbery Lay Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Augustus W. Martin
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) October 9, 1867

8. AGE: Years	Months	Days	If less than one day
76	4	12	-- hr. --- min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Thomas Wolcott Lay
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Annie E. Roach
15. Birthplace Washington, D. C.

16 (a) Informant Mrs. Joseph M. Fox
(b) Address Harrisburg, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. U. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) 2-2-1944 (Date received by Registrar) (b) Signature for Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1944, at 6.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938, to 2-21 1944, and that I last saw her alive on 2-20 1944.

Immediate cause of death Coronary Occlusion — Duration 6 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. Martin M.D.
Address 801 Calvert St Date signed 2-22 1944 M. D.

JAMES

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 14344

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 St Paul St. Balto. 2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Edna J. James

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Walter N. James
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8/16/1878
8. AGE: Years 66 Months 6 Days 3 If less than one day — hr. — min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Henry Herold
13. Birthplace Baltimore

MOTHER
14. Maiden Name Virginia F. Towers
15. Birthplace Virginia

16 (a) Informant Mrs Ruth Fernandez
(b) Address 1607 St Paul Apt 2
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 22/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Northern Ave & Gay St.
18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place
19 FEB 22 1944 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/1944, at 9:45 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1944, to 2/19 1944, and that I last saw her alive on 2/19 1944
Immediate cause of death Cardio-Respiratory Failure — Duration 3 Days.
Due to Hypertensive C.V. Disease & auricular decompensation — Duration Unknown
Due to —
Other Conditions Diabetes Mellitus + Umbilical Hernia
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —
23. Signature G. B. McCadden M. D.
Address Mercy Hospital Date signed —

VS 180

14345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 478

Registered No. 6 14345

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Richwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis H. Hutt

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Clara Hutt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1891

8. AGE: Years	Months	Days	If less than one day
52	4	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name Steptoe D. Hutt
13. Birthplace Virginia

MOTHER
14. Maiden Name Belle Cullison
15. Birthplace Maryland

16 (a) Informant Deerfield
(b) Address 613 Richwood Ave.

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Feby 16/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Greenmount Ave & 30th Sts

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) FEB 20 1944 (b) Huntington Hill Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1944, at 10:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1944 to Feb 19 1944 and that I last saw h(M) alive on Feb 18 1944.

Immediate cause of death Respiratory Failure.

Duration 3 hrs 55 MIN. 5 MOS.

Due to Sarcoma of the Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul R. Zeigler M. D.
Address Mercy Hosp. Date signed 2-19-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 14346

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2217 E Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 E Biddell St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael P. Webes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Josephine Webes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1872

8. AGE: Years	Months	Days	If less than one day
71	6	17	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Webes
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Wagner
15. Birthplace Germany

16 (a) Informant Josephine Webes
(b) Address 2217 E Biddell

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22nd 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Leo G. Crook
(b) Address 1740 N. Patt Park Ave
19 (a) FEB 22 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18th 1944, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Feb 18 1944, and that I last saw deceased alive on Jan 20 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to Asthma Sclerosis Heart Disease

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Keller
Address 1520 N. Broadway Date signed 2-18-44

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G-44347

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 N. Asquith St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 N Asquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Moeller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Louis Moeller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18th 1862

8. AGE: Years	Months	Days	If less than one day
82	1	2	hr. min.

9. Birthplace York Pa (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Peter Yragesser

13. Birthplace Germany.

MOTHER 14. Maiden Name Elizabeth Gruenwalt

15. Birthplace Germany

16 (a) Informant Elizabeth Moeller

(b) Address 1422 N Asquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23rd 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Leo G. Cook

(b) Address 1701-03 N. Patterson Park Ave

19 (a) FEB 22 1944 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20th 1944, at 1030 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22- 1939 to 2-20-1944 and that I last saw her alive on 2-18-1944

Immediate cause of death: Arteriosclerotic Cardio. renal disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Lyhert M. D.

Address 2807 Hartford Ave Date signed 2-21-44

G 14348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 14348 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2424 E. Monument Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 E. Monument Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Joseph Manning

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Carrie (nee Moore)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1874

8. AGE: Years 69 yrs. | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Record & Goldsborough

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Wife
(b) Address 2424 E. Monument Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) FEB 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1944 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1944 to Feb 20 1944 and that I last saw him alive on Feb 19 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 48 hrs.

Due to: Hypertension and Cardio-Vascular Renal Disease — 10 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D.
M. D.
Address 2432 E Monument St Signed 2/22/44

14349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. C 14349

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Feb. 17 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Manhattan Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT EMMET KING

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Beatrice Bates
6 (c) If alive, give age: 43 years
7. Birth date of deceased (mo., day, yr.): 9/2/1893
8. AGE: Years: 50 Months: 5 Days: 20 If less than one day: hr. min
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Freight representative
11. Industry or business: " 2/1/44 P.R.R.

FATHER
12. Name: Patrick King
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Sarah Flaugherty
15. Birthplace: Ireland

16 (a) Informant: Records, U.S.Marine Hospital
(b) Address: Baltimore, Md.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 (a) FEB 23 1944 (Date received by registrar) (b) Hunter for Williams (Registrar)

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH February 22, 1944, at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17, 1944, to Feb. 22, 1944, and that I last saw him alive on Feb. 22, 1944.

Immediate cause of death: Bronchoegenic carcinoma upper lobe right lung with extensive metastasis in ~~bones~~ bones, liver, lymph nodes and mediastinum.

Duration: First noticed 11/25/43

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J.C.Archer
Address: Baltimore, Md. Date signed 2/22/44 M. D.

Va-14311

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G 14350
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home For Incurables
(c) Hospital or institution: 700 W. 40th Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town .....
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mrs. Angelyn V. Wiggin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Henry W. Wiggin
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 28th 1857

8. AGE: Years	Months	Days	If less than one day
86	11	22	..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name James Brewster
13. Birthplace Lebtchtown N. J.

MOTHER
14. Maiden Name Eleanor Johnson
15. Birthplace Baltimore County

16 (a) Informant Home for Incurables
(b) Address 700 W. 40th Street

17 (a) Cremation (b) Date thereof 2/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brea Mount
Location Balto. Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul St

19 (a) FEB 23 1944 (b) Huntington Williams
(Date rec'd by Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1944, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1937, to 2/22 1944, and that I last saw him alive on 2/21 1944.

Immediate cause of death	Duration
Intestinal + Pulmonary Edema	1 Wk.
Due to arteriosclerosis (Involved)	15 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature W. Grafton Hoffenger
Address 214 Medical Arts Bldg Date signed 2/24/44

G 14351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 179X

G 14351 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: Mercy Balto. Gen. Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 742 N. Fulton ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecilia (Cecilla) Rath Ralph (ROLPH)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married, widowed, or~~ divorced: Divorced
6 (b) Name of husband or wife: Charles ROLPH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15th 1909

8. AGE: Years 34 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Hostess apt. House

11. Industry or business

FATHER
12. Name John Joseph Blue
13. Birthplace Brooklyn N.Y.

MOTHER
14. Maiden Name Ruth Sweed
15. Birthplace Balto. Md.

16 (a) Informant Frances R. McKee
(b) Address 1306 W. Lexington St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/25/44 (month) (day) (year)
(c) Cemetery or crematory MtE Olivet
Location Frederick Road

18 (a) Funeral director Williams
(b) Address 1217 St Paul Street

19 (a) FEB 23 1944 (Date rec'd by Registrar) (b) Thomas J. Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21-19XX at 1:30 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bromide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-20- at ? M.
(b) Where did injury occur? 742 N. Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion Overdose Bromides

23. Signature Thomas J. Williams M.D. Medical Examiner.
Date signed 2-21-XX

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G 14352
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 N. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 33 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and State)

10. Usual Occupation Domestic Work

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Evangeline Forrest
(b) Address 4 318 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Maryland

18 (a) Funeral director Mrs Katie B. Williams
(b) Address 222 N Schroeder St

19 (a) FEB 23 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1944 at 9 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1944 to Feb. 21 1944 and that I last saw h[illegible] alive on Feb 21 1944.

Immediate cause of death Hypertensive Heart Disease — Duration

Due to

Due to

Other Conditions Myocardetis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Banfield M. D.
Address Provident Hosp. Date signed 2-24-44

G 14353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 107

G 14353 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Lamond Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 E 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Lela Dunivant Norris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	M

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 - 1944.

8. AGE: Years	Months	Days	If less than one day
	1	14	hr. min

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John C. Norris
13. Birthplace Kansas City Mo.

MOTHER
14. Maiden Name Lenny C Dunivant
15. Birthplace Wheatland Mo.

16 (a) Informant Mrs J. C. Norris
(b) Address 119 E 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director R. Lee Offer
(b) Address 4644 York Rd.

19 FEB 23 1944 (Local Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21-44 1944, at 8.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4- 1944, to 2-21 1944, and that I last saw her alive on 2-20 1944.

Immediate cause of death Respiratory failure — Duration: over

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Morris M. D.
Address U. M. H. Date signed 2-23-44

G 14354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 14354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MEMORY RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 N. Milton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET EVA FORNOFF

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1860

8. AGE: Years 83 | Months 3 4 | Days | If less than one day: hr min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At. home
11. Industry or business

FATHER
12. Name Adam Fornoff
13. Birthplace Germany

MOTHER
14. Maiden Name Eve Kahler
15. Birthplace Germany

16 (a) Informant William Fornoff
(b) Address 508 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Balto. County, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address North Ave. & Broadway

19 (a) FEB 23 1944 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1944 at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15, 1944, to Feb 20, 1944, and that I last saw her alive on Feb. 19 1944.

Immediate cause of death: Myocarditis (chronic) — Duration: ?
Due to
Due to
Other Conditions Probable Gall-Stones
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cesarano M. D.
Address 5-4 Drury Lane Date signed 2/22/44

G 14355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V G 14355 Registered No. 186a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 0 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 N. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna D. Byrne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife Jno B. —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	9	10		

9. Birthplace Balto (town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name — Feller
13. Birthplace Bit Riehl

MOTHER
14. Maiden Name —
15. Birthplace Bit

16 (a) Informant Miss Byrne
(b) Address 125 N. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.

18 (a) Funeral director John J. Moran
(b) Address 3000 E. Balto St.

19 (a) FEB 23 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1944 at 4:35 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of neck (1st and 2nd cervical vertebrae)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb 20 1944 9 A M.
(b) Where did injury occur? 125 N. Ellwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall down stairs

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 2-20-44

VS 151

G 14356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G 14356 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Md. Gen.
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Winston Av.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mr. Harry B. Wells

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Louisa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb-28-1874

8. AGE: Years	Months	Days	If less than one day
69	11	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name ? Wells
13. Birthplace Md.

MOTHER
14. Maiden Name ? Revell
15. Birthplace Md.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Loudon Park Ave

18 (a) Funeral director Edwin A. Moran
(b) Address 4706 Greenmount Av

19 (a) FEB 23 1944 (Date rec'd by registrar) Huntington Williams III Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20/ 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18- 1944, to 2-20 1944, and that I last saw h.l.m. alive on 2-20 1944.

Immediate cause of death

Cerebral hemorrhage

Due to Hypertension, arteriosclerosis CVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. H. Williams M. D.
Address Md. Gen. Hosp Date signed Feb. 20, 1944

G 14357 ✓ G 14357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hosp. 9th 3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1506 N. Luzerne Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

✓

3 (a) FULL NAME Helen Elizabeth Britcher

3 (b) If veteran, name war —

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 5, 1933

8. AGE: Years	Months	Days	If less than one day
10	9	16	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business .....

MOTHER / FATHER

12. Name Wilbur Britcher

13. Birthplace Baltimore, Md.

14. Maiden Name Helen Haddy

15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Record.

(b) Address .....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Location E. North. Ave

18 (a) Funeral director John A. Modom

(b) Address 3000 E. Baltimore St.

19 FEB 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1944 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1944 to Feb. 21 1944, and that I last saw her alive on Feb. 21 1944.

Immediate cause of death Respiratory Failure — Duration .....

Due to Lobar Pneumonia .....

Due to / .....

Other Conditions Acad Dyscrasia & Neoplasms (Include pregnancy within 3 months of death) .....

Date of operation .....

Major findings of operation: .....

of autopsy: Neoplasms and Lobar Pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature G. E. Hornbrook M. D.

Address Mercy Hospital Date signed 2/24/44

G 14358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 14358

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4514 Wanstead Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Keehan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Henry V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1866

8. AGE: Years	Months	Days	If less than one day
77	7	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Samuel T. Walker
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Lewis
15. Birthplace Md

16 (a) Informant Mrs. Elizabeth Holland
(b) Address 4514 Wanstead Ave

17 (a) Burial (b) Date thereof 2-23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Leonard Ring
(b) Address 5 E. Fulton St

FEB 23 1944
(Date rec'd by registrar)

(b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1944 to Feb. 20 1944 and that I last saw her alive on Feb. 20 1944

Immediate cause of death Cerebral Hemorrhage — Duration 10 days

Due to Generalized arteriosclerosis — 5

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Schreiber M. D.
Address 5 E. Fulton Ave Date signed 2-23-44

14359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 14359
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5705 High Gate Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5705 High Gate Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ESTELLE MAE WILLIAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Russell F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1876

8. AGE: Years	Months	Days	If less than one day
67	3	27	16 hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry C. Gartside
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Emma Foster
15. Birthplace Balto., Md.

16 (a) Informant Mr. Russell F. Williams
(b) Address 5705 High Gate Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address North & Pa., Balto. Md.

19 (a) FEB 23 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/44 19 , at noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1944, to Feb. 21 1944, and that I last saw h[illegible] alive on Feb. 21 1944.

Immediate cause of death Cardiac Dilatation and Failure — Duration 2 weeks

Due to Hypertension Heart Disease — 7-8 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Palmer Heisman M. D.
Address 2424 Eutaw Place Date signed 2-22-44

G 14360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

25

G 14360 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 N. Monroe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES LARRY COKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1940

8. AGE: Years	Months	Days	If less than one day
4	--	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name James W. Coker
13. Birthplace Mississippi

MOTHER
14. Maiden Name Minnie Wissert
15. Birthplace Md.

16 (a) Informant Mr. James W. Coker
(b) Address 805 N. Monroe St. 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/ 1944, at 1 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1944 to 2/21 1944, and that I last saw h alive on 2/21 1944.

Immediate cause of death	Duration
Broncho-pneumonia	1 day
Due to Measles	6 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer L. Todd
Address 735 N. Fulton Ave Date signed 2/22/44

14361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14361
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Forest Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lester Duncan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Lena Duncan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 43 | Months 4 | Days | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Ira Duncan
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ellen Green
15. Birthplace North Carolina

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Feb 25 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beaver Creek
Location West Jefferson, N.C.

18 (a) Funeral director Martin Gelbert
(b) Address Lane Tyndall & Mc Arthington Williams, W.Va.

19 (a) FEB 23 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1944, at 7:25 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 18, 1944
(b) Where did injury occur? Forest Hill, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Clothing caught fire from [illegible]

23. Signature Robert L. Baker M.D.
Medical Examiner.
Date signed February 22, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 14862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 14362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1332 No Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (or outside city or county give name of township and give town)
(d) Street No. 1332 No Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Sarah Mendelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Shrago
13. Birthplace Russia

MOTHER
14. Maiden Name Tobie
15. Birthplace Russia

16 (a) Informant Solomon Mendelson
(b) Address 1332 No Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-44
(c) Cemetery or crematory Hebrew Rosedale
Location Anshe Ashard Cong

18 (a) Funeral director Jacob Peiros Inc
(b) Address 1439 E. Balto St

FEB 23 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1944 at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 21 1944 and that I last saw h-r alive on Feb 21 1944.

Immediate cause of death Myocarditis
Cardiac dilatation
Due to Diabetes Mellitus

Due to

Other Conditions Acute cardiac dilatation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj Kadrin M. D.
Address 2306 Eutaw Pl Date signed 2-22-44

(over)

14363
448149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

G 14363
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 YRS

13-1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 Callow Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Blumberg
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Gilbert
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 3 - 21 - 10

8. AGE: Years	Months	Days	If less than one day
33	11	1	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Bronstein
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Weinstein
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Highway & Hamilton Ave

18 (a) Funeral director Jack Levin Funeral Home
(b) Address 1439 E. Baltimore St.

19 FEB 23 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1944, at 12:12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 22 1944, to Feb 22 1944, and that I last saw her alive on Feb 22 1944.

Immediate cause of death	Duration
Cardiac failure and Terminal Pulm. Edema	7 days
Due to Myocarditis and sclerosis	5 mo
Due to Subacute bacterial endocarditis	7 mo.
Other Conditions Probable cerebral hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcus L. Flourney, M. D.
Address 2 E. Mt. Royal Ave Date signed 2/22/44

VS 150

14364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 14364
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 N. Gilmore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Gilmor (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ampy Wintfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) ~~Single, married~~, widowed, ~~or~~ divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1887

8. AGE: Years 56 | Months 6 | Days | If less than one day: hr. min.

9. Birthplace Middlesex, Co. Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name L. Wintfield
13. Birthplace Middlesex Co. Va.

MOTHER
14. Maiden Name Mildred Thomas
15. Birthplace Middlesex Co. Va.

16 (a) Informant Richard Talbert
(b) Address 833 Fairfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. St., Capitol

18 (a) Funeral director Robert W. Gilliam
(b) Address 1515 McElderry St

FEB 23 1944 (Date rec'd by registrar) Huntington for William A. M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20/44, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25, 1943, to Feb. 20, 1944, and that I last saw him alive on Feb. 17, 1944.

Immediate cause of death Chronic myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell, M. D.
Address 718 Dolphin St. Date signed 2-22-44

VS 3

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Any alteration or erasure invalidates this certificate. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14365

~~14365~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2201 Cold Spring Avenue
(c) Hospital or institution:
Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) About 78 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Cold Spring Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Elizabeth V. Stack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles C. Stack
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------- 1866

8. AGE: Years	Months	Days	If less than one day
About 78	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name James Clarke
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Cockley
15. Birthplace Maryland

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ /44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

FEB 23 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1944, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944 to Feb 22 1944, and that I last saw h[illegible] alive on Feb 15 1944.

Immediate cause of death: a. Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos Tuttleman M. D.
Address 7324 Reisterstown Rd Date signed 2/23/44

VS 150

C 14366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

C 14366
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:

10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Sr. M. Dietmara Mc. Donnell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1856

8. AGE: Years	Months	Days	If less than one day: hr.	min.
87	2	5		

9. Birthplace Boston Mass. (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business Religious

FATHER
12. Name John Mc. Donnell
13. Birthplace Cork Ireland

MOTHER
14. Maiden Name Mary Splainne
15. Birthplace Ireland

16 (a) Informant Sr. M. Stan, Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24/44 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Glen Arm

18 (a) Funeral director Geo. M. Fonticoba Son
(b) Address 511 N. Wolfe St

19 FEB 23 1944 (b) Huntingtown Williams M.D.
(Date received by local reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sr. M. Dietmara Feb 22 1944, at 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1933, to Feb. 22, 1944, and that I last saw her alive on Feb. 10 1944.

Immediate cause of death
Multiple Sclerosis
Arteriosclerosis
Due to
Due to Myocarditis

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. J. Kirby
Address 1106 E. North Ave. Date signed 2/23, 44. D.

G 14367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14367 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5714 Cross Country Blvd
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5714 Cross Country Blvd (If rural give location)
(e) Citizen of foreign country? — No (Yes or No)
If yes, name country —

3 (a) FULL NAME Frederick Benjamin Eisenbrandt

3 (b) If veteran, name war — no. —

3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine S. Eisenbrandt

6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) July 24 1863

8. AGE: Years 80 | Months 7 | Days 6 | If less than one day hr. — min. 29

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired Merchant.

11. Industry or business — — —

FATHER
12. Name Christian F. Eisenbrandt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jeanette Wild
15. Birthplace Germany

16 (a) Informant Mr. Fred H. Eisenbrandt (son)
(b) Address 7102 Bristol Rd - Bellair Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb - 25 - 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart Mason Co.
(b) Address 1112 North Ave

FEB 23 1944

19 (a) — (Date rec'd by registrar) (b) Huntington Hilliard (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 22 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1944 to Feb 22 1944
and that I last saw h— alive on Feb - 22 1944

Immediate cause of death Coronary Thrombosis — Duration 30 hrs
Due to Generalized Arteriosclerosis — Indef.
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Nathaniel M Beck M.D.
Address 2727 N. Charles Date signed Feb 25

G 14368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G 14368 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4101 Dorchester Rd
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 1 5
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 4101 Dorchester Rd
(If rural give location)
(e) Citizen of foreign country? - No - (Yes or No)
If yes, name country —

3 (a) FULL NAME Thomas Walter Bell

3 (b) If veteran, name war none

3 (c) Social Security Account No. 216-07-1616

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ellen L Bell

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan 8-1875

8. AGE: Years 69 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation Clerk - Pinna

11. Industry or business B R Company

FATHER 12. Name William S Bell

13. Birthplace Virginia

MOTHER 14. Maiden Name Rosa Doughty

15. Birthplace Virginia

16 (a) Informant Mrs Ellen L Bell (wife)

(b) Address 4101 Dorchester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville

18 (a) Funeral director's Stewart & Mooney Co.

(b) Address 108 W Mt Royal Ave

19 (a) FEB 23 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1944 at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1944 to Feb 19 1944 and that I last saw h/l alive on Feb 19 1944.

Immediate cause of death Coronary Thrombosis — Duration 12hrs

Due to Myocarditis — 3yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Davies M. D.

Address 800 W 33rd Date signed 2-21-44

G 14369

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 14369
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 Woodward St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Woodward St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace E. Mandell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Geo Mandell
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.): Dec 19th 1884
8. AGE: Years 59 | Months 2 | Days 2 | If less than one day: hr min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: home work
11. Industry or business: at home

FATHER
12. Name: Isaac R Bryan
13. Birthplace: N Carolina

MOTHER
14. Maiden Name: Mary Richardson
15. Birthplace: 822 Woodward St

16 (a) Informant: Mr Geo Mandell
(b) Address: 822 Woodward St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof? 2-24-44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem
Location: 3801 Pedlar St Apt E

18 (a) Funeral director: John F Conway Son
(b) Address: 901 Hastings St Huntington Williams, W. Va.

19 FEB 23 1944 (Date received by local registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 21st 1944 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1944 to Feb 21 1944 and that I last saw him alive on Feb 21 1944

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Sequeth M. D.
Address 1729 N Eutaw St Date signed 2-22-44

VS 150

G 14370
449300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
1937

G 14370
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write out full name and street address. Use figures for dates of birth. Do not use ditto marks. If unknown, or if not applicable, write none. Where a choice is given, underline the correct one. Cause of death must be certified to the best knowledge and belief of the physician. Do not write in the space reserved for registrar's use. Do not fold this certificate. Use typewriter or pen and ink. Be sure that the information is complete and correct before it is filed. Any person who knowingly makes a false statement in this certificate is guilty of a misdemeanor and subject to a fine of not more than $100.00 or imprisonment for not more than 30 days, or both. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Penna. Ave. Towson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosetta Fuller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: black
6 (a) Single, married, widowed, or divorced: wid.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1859
8. AGE: Years 56 | Months | Days | If less than one day: hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Amos Tolbert
13. Birthplace

MOTHER
14. Maiden Name Cornelia
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23-1944 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Md
18 (a) Funeral director Sportsmans & Wright
(b) Address 72 Asquith St
19 (a) FEB 23 1944 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 19 44 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 19 44 to Feb. 18 19 44 and that I last saw h alive on Feb. 18 19 44

Immediate cause of death: Respiratory failure — Duration: 1 hour
Due to: Pulmonary edema — 5 days
Due to: Hypertension cardio-vascular disease — year
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. Blackwright M. D.
Address Johns Hopkins Date signed 2-20-44

G 14371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122a

G 14371 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16da
(e) Length of stay in Baltimore (yrs., mos., or days) 16da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon R. Tawes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed or divorced~~.

6 (b) Name of husband or wife Mrs. Mildred Tawes

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 10-1-1889

8. AGE: Years 54 55 | Months X4 | Days X14 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland ? (Town, county, and state)

10. Usual Occupation Amusement Foreman

11. Industry or business

FATHER
12. Name Wesley Tawes
13. Birthplace Md.

MOTHER
14. Maiden Name Eugenia Cox
15. Birthplace Md.

16 (a) Informant Deceased
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-44 (month) (day) (year)
(c) Cemetery or crematory Crisfield Cem.
Location Crisfield Md.

18 (a) Funeral director Richard O. Barrington
(b) Address 21 W. 25th St.

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams Funeral Home

FEB 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15-44, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1944, to 2-15 1944 and that I last saw h / M alive on 2-15 1944.

Immediate cause of death Pulmonary Embolism — Duration

Due to Thrombophlebitis

Due to

Other Conditions Tertiary Lues
Bilateral Herniaplasty
(Include pregnancy within 3 months of death)

Date of operation 2-10-44

Major findings of operation: Bilateral Inguinal Hernia

of autopsy: not performed.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Range M. D.
Address Date signed

14372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

G 14372 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BURNS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hours.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Grindall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Anna [redacted] WROBLEWSKI

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 22, 1903

8. AGE: Years 41 | Months — | Days — | If less than one day hr. min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation TUBE OPERATOR

11. Industry or business PRATT. CORPORATION

FATHER 12. Name STANLUS WROBLEWSKI

13. Birthplace POLAND

MOTHER 14. Maiden Name FRANCES-BANOWSKI

15. Birthplace POLAND

16 (a) Informant MRS HELEN NERODA.

(b) Address 410 E GRINDALL ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB-25-44 (month) (day) (year)

(c) Cemetery or crematory HOLY ROSARY CEM. Location BALTO Co.

18 (a) Funeral director Bernard G. Hosle

(b) Address 121 E. [illegible] St. (Name of St., Ave., or Rural Route)

19 (a) FEB 23 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1944, at 5.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4-1943 to 2/22/1944, and that I last saw h[illegible] alive on 2/22 1944.

Immediate cause of death Gangrene of lung.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl E. Lubato M. D.

Address 213 Light St. Date signed 2/22/44

VS 180

14373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/a

G 14373 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 Cherry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 CHERRY ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES DREXLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife ALBINA DREXLER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 6th 1876

8. AGE: Years	Months	Days	If less than one day
68	0	15	hr. min.

9. Birthplace AUSTRIA. (Town, county, and state)
10. Usual Occupation LABORER.
11. Industry or business

FATHER
12. Name ALEXANDRRIA. DREXLER
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name PAULINE TAUBER
15. Birthplace AUSTRIA

16 (a) Informant LOUIS DREXLER
(b) Address 427 CHERRY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB-24-44 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A-A Co

18 (a) Funeral director Bernard E Hale
(b) Address 121 E 21st St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 24 1944 at 12.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7/ 1944 to 2/21/ 1944, and that I last saw him alive on 2/20/ 1944.

Immediate cause of death: Hypertensive cardio vascular renal disease — Duration: ?

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M. D.
Address 1226 Hanover St Date signed 2/22/ 1944

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G 14374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14374 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1435 E. Federal Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Mueller

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	212-03-4047	Male	White	Married

6 (b) Name of husband or wife Agnes Ahran
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 17th, 1882

8. AGE: Years	Months	Days	If less than one day
61	8	4	### hr. ### min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Office Janitor
11. Industry or business C.M.E.A. Balto. City

FATHER
12. Name Henry Mueller
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ella Litz
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Agnes Mueller (Wife)
(b) Address 1735 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Filed FEB 23 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21st, 1944 at 11 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1944 to Feb. 21 1944. and that I last saw [illegible] alive on Feb. 21 1944.

Immediate cause of death Coronary thrombosis — Duration 12 hrs.
Due to Arteriosclerotic C-V disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. W. H. Granger M. D.
Address 1402 E. Lanvale St. Date signed 2-22-44

14375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 14375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson Ave & Hilsland St
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 856 W 37th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James B Sullivan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elsie May Sullivan
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1893

8. AGE: Years	Months	Days	If less than one day
60	6	10	..... hr. ..... min.

9. Birthplace Mass. (Town, county, and state)
10. Usual Occupation Retired - Lithographer
11. Industry or business

FATHER
12. Name Daniel Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Victoria Stuart
15. Birthplace Scotland

16 (a) Informant Elsie May Sullivan
(b) Address 856 West 37th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22 - 44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) FEB 23 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1944 at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1944 to Feb 18 1944 and that I last saw h/m alive on Feb 18 1944.

Immediate cause of death	Duration
Congestive heart failure	
Due to	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randall Williams M. D.
Address West Baltimore General Hospital Date signed 2/18/44

VS 150

G 14376

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 14376

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 S. Hammond
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country France

3 (a) FULL NAME Josephine Harris Vessel Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ruben Vessel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 47 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Irvin Harris
13. Birthplace Va.

MOTHER
14. Maiden Name Mary
15. Birthplace Va.

16 (a) Informant Alberta Ray
(b) Address 322 S Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 W Lafayette Ave

Registered by (Date) FEB 23 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20- 1944, at 4 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb 20 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 14377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14377 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith May Woodley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Woodley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 12, 1906

8. AGE: Years 37 | Months 6 | Days 7 | If less than one day: hr. min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Frank Davis
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Alice Young
15. Birthplace: Balto. Md.

16 (a) Informant: Gladys Ferrell
(b) Address: 1538 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 23 44 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial
Location

18 (a) Funeral director: Mrs. Victor K. Williams
(b) Address: 922 N. Schroeder St

19 (a) (b) Baltimore, Md.
Date received by Registrar — Registrar

FEB 28 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1944, at 10:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Thrombocytopenic purpura

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 20 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 14378

CERTIFICATE OF DEATH

G 14378

PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 N. Strieker St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME James Williams

If U. S. Veteran specify W. or S.

(a) Residence: No. 228 N. Strieker St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	Colored	

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) July 20, 1894

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	6	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Essex Co Virginia

FATHER

13. NAME Phillip Williams

14. BIRTHPLACE (city or town) (State or country) Virginia

MOTHER

15. MAIDEN NAME Martha Dixon

16. BIRTHPLACE (city or town) (State or country) Va.

17. INFORMANT Mrs. Anna Mae Williams

(Address) 228 N. Strieker St.

18. BURIAL, CREMATION OR REMOVAL

Place Mt. Lebanon Cem. Date Feb. 23, 1944

19. UNDERTAKER Miss Katie R. Williams

(Address) 332 N. Monroe St.

20. FILED ..... 19.... Registrar.

FEB 23 1944

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 2-18-, 1944

22. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1944 to Feb 18, 1944

I last saw him alive on Feb. 18, 1944 Death is said to have occurred on the date stated above, at 3 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute pulmonary tuberculosis	5 weeks
Other contributory causes of importance:	

Was an operation performed? No Date of ~

For what disease or injury? ~

Name of operation

What test confirmed diagnosis? Clinical Signs & Symptoms Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ~

(Signed) John E. L. Campbell M. D.

(Address) 639 N. Carey St., Balto. Md.

Huntington Williams, M.D.

INFORMATION should be carefully supplied. AGES should be given for every person. If exact statement of state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 14379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 14379 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2 N. Calvert Street

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1603 N. Stricker St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Mary Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife James Patrick Evans

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9 1873

8. AGE: Years	Months	Days	If less than one day
70	5	13	hr min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Philip Little

13. Birthplace Ireland

MOTHER

14. Maiden Name Elisa Hammer

15. Birthplace Ireland

16 (a) Informant Mrs Mary Evans

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Bath Mt.

18 (a) Funeral director Guy A. Farley

(b) Address Fulton & Fayette

Filed 2-23 1944 (Date filed by registrar)

(b) Huntington Mitchell, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1944, at 6:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 1944 to 2/22 1944, and that I last saw he[r] alive on 2/22 1944.

Immediate cause of death: Cardio Respiratory Failure — Duration: 2 weeks.

Due to Cerebro-vascular C.V. Disease — Duration: 2 mos.

Due to Hypertension & congestive heart failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. B. Mitchell M. D.

Address Date signed

VS 180

G 14380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14380 Registered No. 121

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W Fayette
(c) Hospital or institution Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna S Tessler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 14 1874

8. AGE: Years 69 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Sebastian Dotterweich
13. Birthplace Germany

MOTHER 14. Maiden Name — Fischer
15. Birthplace Maryland

16 (a) Informant Lawrence Kegeles
(b) Address 37 Cornbrook Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George F Talbert
(b) Address Talbert & Fayette

19 (a) 2-23-1944 (Date rec'd by registrar) (b) Registrar
Huntington Williams, MD

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/1944 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1944 to 2/21 1944 and that I last saw her alive on 2/21 1944

Immediate cause of death Coronary thrombosis
Duration 8 days

Due to Prolonged Hypothermia

Due to Leukemia

Other Conditions Post-operative appendectomy (Include pregnancy within 3 months of death)

Date of operation 2/13/44

Major findings of operation: Acute appendicitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Haywood Rogers M. D.
Address Bon Secours Hosp Date signed 2/21/44

G 14381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 14381 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 S Janney St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 S Janney St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel N Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Agatha Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13 1860

8. AGE: Years: 84 | Months: - | Days: 11 10 | If less than one day: hr. min.

9. Birthplace Wheeling W Va (Town, county, and state)

10. Usual Occupation Laboring
11. Industry or business

FATHER
12. Name Joseph Jones
13. Birthplace W Va

MOTHER
14. Maiden Name Henretta Glenn
15. Birthplace W Va

16 (a) Informant Mrs Gertrude Shiplett
(b) Address 104 S Janney St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 23/44 (month) (day) (year)
(c) Cemetery or crematory Wheeling W Va
Location W Va

18 (a) Funeral director Ulmer Funeral Home
(b) Address 2008 Orleans St

19 (a) FEB 23 1944 (Date rec'd by registrar) Hunting for Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to 2/23 1944 and that I last saw h. alive on 2/22 1944.

Immediate cause of death Myocarditis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Flow M. D.
Address 3215 Eastern Ave Date signed

G 14382

G 14382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 Abbottston St.
(c) Hospital or institution:
at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Abbottston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Spangler

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edith C. Kumar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1872

8. AGE: Years 71 | Months 2 | Days 14/2 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Meth Brother Clerk

11. Industry or business Shipping Dept

FATHER
12. Name James Spangler
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Ray
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Edith C. Kumar
(b) Address 1505 Abbottston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 1505 Abbottston St

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St Huntington Station, Md.

19 (a) FEB 23 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1944, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1938 to Feb 22 1944
and that I last saw h~~im~~ alive on Feb 21 19 44

Immediate cause of death: Cerebral thrombosis — Duration: 2 days

Due to: hypertension arteriosclerotic Cardiovascular disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Jack J. Singer M. D.
Address 506 E Northern Date signed 2-23-44

VS 3

G 14383

BALTIMORE CITY HEALTH DEPARTMENT

TN. 86170 CERTIFICATE OF DEATH 55E

G 14383 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Albemarle St (If rural, give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country Poland

3 (a) FULL NAME John Molinsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Hazel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20, 1884

8. AGE: Years 59 | Months 1 | Days 24 23 | If less than one day: hr min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location JOHN HOPKINS MEDICAL SCHOOL FEB 23 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 23 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1944 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1944 to 2/13 1944 and that I last saw him alive on 2/13 1944.

Immediate cause of death: Ca. Carcinomatosis - primary site unknown — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post (anat.)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman M.D.
Address A C H Date signed 2/24

VS 180

0750

G 14384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14384 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
1531 Madison Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Pistel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired,
11. Industry or business

FATHER
12. Name George Pistel
13. Birthplace Balto

MOTHER
14. Maiden Name Sarah Hund
15. Birthplace Balto Md

16 (a) Informant Dr. W. H. Smith
(b) Address 3429 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 44 (month) (day) (year)
(c) Cemetery or crematory Green Mt Cem
Location Nort Green Mt Grves

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 900 Eutaw Place
(c) FEB 23 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1944, at 3:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) How did injury occur?

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed February 23 1944

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14385

G 14385 .1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMAIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2605 Elsinor Ave.

(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2605 Elsinor Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country .....

3 (a) FULL NAME James Frank Kenly

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-22-0199

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mavourneen Williams

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April 18, 1877

8. AGE: Years	Months	Days	If less than one day
66	10	3	hr min.

9. Birthplace Harford County, Md. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business Federal Reserve Bank

FATHER 12. Name James Frank Kenly

FATHER 13. Birthplace Harford County, Md.

MOTHER 14. Maiden Name Sarah V. Hanway

MOTHER 15. Birthplace Md.

16 (a) Informant Mrs. M. W. Kenly

(b) Address 2605 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1906 Eutaw Place

19 (a) (Date rec'd) Hunter Williams, M.D. Registrar

FEB 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944, to Feb 21 1944, and that I last saw him alive on Feb 21 1944.

Immediate cause of death — Duration

Coronary Occlusion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. R. C. Kenly

Address 2757 W. North Ave. Date signed 2/23/44

G 14386 BALTIMORE CITY HEALTH DEPARTMENT G 14386

CERTIFICATE OF DEATH 1/61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 431 N. Broadway

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 431 N. Broadway (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Thomas Henderson Senior

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lela

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29. 1873

8. AGE: Years 71 | Months | Days 24 | If less than one day hr. min.

9. Birthplace Pocomoke City Md (Town, county, and state)

10. Usual Occupation Produce Buyer

11. Industry or business

FATHER 12. Name Thomas Henderson

13. Birthplace Pocomoke City Md

MOTHER 14. Maiden Name Jane Ellis

15. Birthplace Pocomoke City Md

16 (a) Informant Mrs Lela Henderson

(b) Address 431 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)

(c) Cemetery or crematory Pocomoke City Md Maryland

Location

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-26 W. North ave

19 (a) FEB 23 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1944, at 4 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1944, to 2/22 1944, and that I last saw h/m alive on 2/22 1944.

Immediate cause of death Bronchio-Pneumonia — Duration 1 week

Due to

Due to

Other Conditions Diabetes, Malaturia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph S. Blum M.D. M.D.

Address 206 E. Preston St Date signed 2/24/44

G 14387

Order #1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14387 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible]
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [illegible] Unknown White Male

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
68 ?			hr. min

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or Crematory PUBLIC CEMETERY FEB 21 1944
Location
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) FEB 23 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1944, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 9 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 14388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14388 / 107

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S.Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): Just arrived

2. USUAL RESIDENCE OF DECEASED:
(a) State: Pa. (b) County:
(c) City or town: Mt. Pleasant (Westmoreland County)
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 618 Smithfield Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: ABRAHAM GANTOS, JR.

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 182-14-2365

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 31, 1922

8. AGE: Years	Months	Days	If less than one day: hr.	min
22	0	22		

9. Birthplace: Mt. Pleasant, Pa. (Town, county, and state)
10. Usual Occupation: Messman
11. Industry or business: Merchant Marine

FATHER
12. Name: Abraham Gantos
13. Birthplace: Cyria

MOTHER
14. Maiden Name: Mary K. Saloom
15. Birthplace: Cyria

16 (a) Informant: Records, U.S.Marine Hospital
(b) Address: Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 26 44 (month) (day) (year)
(c) Cemetery or crematory Mt Pleasant Pa
Location Cemetery named

18 (a) Funeral director Wellington Est, Inc
(b) Address 121 S. Eutaw St, Balto

19 (a) 1944 (Date received by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MS-51159

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: Feb. 22, 1944, at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21, 1944, to Feb. 22, 1944, and that I last saw him alive on Feb. 22, 1944.

Immediate cause of death: Bilateral bronchial pneumonia with marked edema and congestion

Due to: Marked toxic myocarditis with rather marked dilatation of both auricles & both ventricles.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

Duration	Onset
Approx. 3 weeks	
Unk.	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify) (Place)
(e) Means of injury:

23. Signature: O.C.Archer M. D.
Address: Baltimore, Md. Date signed 2/23/44

G 14389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14389 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland (Chas. & 33rd Sts)
(b) Street address Charles Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 33rd Sts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) name country

3 (a) FULL NAME DAISY Rosamund Yeatmen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife D. Ammen Yeatman
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr) --------

8. AGE: Years	Months	Days	If less than one day
65	---	---	-- hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Edward Hundle
13. Birthplace Md.

MOTHER
14. Maiden Name Cecelia Freeman
15. Birthplace Md.

16 (a) Informant Jennie P. Broadhurst
(b) Address Jamesville, N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Myers and Son
(b) Address 805 N. Calvert Street

19 (a) FEB 2 1944 (Date rec'd by registrar) (b) Huntingtown, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1944 at 2:30 A M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 2/22/44

C 14390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C 14390 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3728 Edmondson Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) About 65 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3728 Edmondson Avenue (If rural give location)
(e) Citizen of foreign country? --------- (Yes or No)
If yes, name country ---------

3 (a) FULL NAME Mary Gertrude Sperzel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph A. Sperzel
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) ---------- 1877

8. AGE: Years	Months	Days	If less than one day
About 65	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Ferdinand Goodhues
13. Birthplace New York

MOTHER
14. Maiden Name Elizabeth Douglas
15. Birthplace Baltimore, Maryland

16 (a) Informant Joseph A. Sperzel
(b) Address 3728 Edmondson Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) ---------- (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

FEB 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1944 at 5:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 1943 to Feb 22 1944 and that I last saw h alive on Feb 22 1944

Immediate cause of death Coronary Thrombosis — Duration 3 hrs

Due to Arteriosclerosis — Duration yrs

Due to ---

Other Conditions ---

(Include pregnancy within 3 months of death)

Date of operation ----------

Major findings of operation: ----------

of autopsy: ----------

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ---------- at ---------- M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. S. Gray M.D.
Address 3727 Edmondson Ave Date signed 2/23/44

14391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

G 14391
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Booth St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Booth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B. Helwig

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widow

6 (b) Name of husband or wife late Andrew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1868

8. AGE: Years	Months	Days	If less than one day
75	7	6	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Hakerkorn
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Martha Meyer
(b) Address 2202 Booth St

17 (a) Burial (b) Date thereof 2-26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md

18 (a) Funeral director Hamp H. Wilkes
(b) Address 4106 Edmondson Ave

19 (a) [illegible] (b) [illegible]
[illegible] FEB 23 1944 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1944 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1943 to 2/22 1944, and that I last saw h alive on 2/21 1944.

Immediate cause of death Carcinoma of Rectum — Duration 1 year

Due to

Due to

Other Conditions Metastasis to Brain

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas A Cramer
Address 2115 W Belt St Date signed 2/25/44

14392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G 14392
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 W. Burnett St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dinah Lee Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Hill
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dina Porcato
15. Birthplace Balto. Md.

16 (a) Informant Mr. Wm. Hill
(b) Address 116 W. Burnett St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Harid Sondheim & Son
(b) Address 902 Eutaw Place

19 (a) Date received FEB 24 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1944 at 9:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1944 to 2-23 1944. and that I last saw her alive on 2-23 1944.

Immediate cause of death: Subarachnoid Hemorrhage. atelectasis

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas P. MacDonald M. D.
Address 1213 Light St Date signed 2-25-44

C 14393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. C 14393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3824 Sequoia Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

1548

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3824 Sequoia Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME SOPHIA B. BIRCK

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Charles W. Birck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1873

8. AGE: Years 70 | Months 8 | Days 22 | If less than one day: hr. min

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Khamer
13. Birthplace Phila., Pa.

MOTHER
14. Maiden Name Mary Emma Hill
15. Birthplace Phila., Pa.

16 (a) Informant Mrs. Emma B. Cornwall
(b) Address 3824 Sequoia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 24 1944 (Date rec'd by registrar) (b) Huntington Hillsinger, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/ 1944, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28th to 1944, to Feb 22 1944, and that I last saw h[illegible] alive on Jan 18th 1944.

Immediate cause of death: Heart Failure — Duration: 2 hrs

Due to Exhaustion — 1 month

Due to Rectal Carcinoma — 2 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Poulton, M. D.
Address 3949 Gunston Blvd Date signed 2/24/44

C 14394

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 830

Registered No. G 14394

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully completed. Try to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 Cedric Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Cedric Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

15

3 (a) FULL NAME JOSEPH F. GERLACH

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Nettie M. Gerlach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/1871

8. AGE: Years	Months	Days	If less than one day
72	1	22	hr. min

9. Birthplace Salina, Ohio (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Gerlach
13. Birthplace Ohio

MOTHER
14. Maiden Name Mary --
15. Birthplace --

16 (a) Informant Mr. Arthur F. Gerlach, son
(b) Address 4420 Underwood Rd.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 FEB 24 1944 (b) [illegible] (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1944, at 6:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-21 1944, to Feb-22 1944, and that I last saw h[illegible] alive on Feb 22 1944.

Immediate cause of death: Cerebral hemorrhage and paralysis — Duration: 2 days
Due to Hypertension — 7
Due to advanced arteriosclerosis
Other Conditions arteriosclerosis — 2
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter L Tibbott M. D.
Address 2220 Garrison Blvd Date signed

14395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G 14395
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 756 Dolphin Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 756 Dolphin St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Braxton

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	F	C	Married

6 (b) Name of husband or wife Jerome
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 4/7/1883

8. AGE: Years	Months	Days	If less than one day
60	10	14	hr. min

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Domestic

FATHER
12. Name Nathaniel Dyson
13. Birthplace Md.

MOTHER
14. Maiden Name Theresa Wilson
15. Birthplace Md.

16 (a) Informant Jerome Braxton (Husband)
(b) Address 756 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (Date rec'd by registrar) FEB 24 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/44 19 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9.22 1943 to 2.21 1944 and that I last saw her alive on 2.19 1944

Immediate cause of death: Hypertensive cardio-renal disease — Duration 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne
Address 1500 E Madison St Date signed 2/23 M. D.

14396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

✓ Registered No. G 14396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 439 Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (albert Jester) Ernest A. Jesters

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Justine
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1918

8. AGE: Years	Months	Days	If less than one day
25	3	11	hr. min.

9. Birthplace Balto. Co.
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Sparrows Pt. Shipyards

FATHER
12. Name James E. Jester
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Bessie V. Bolt
15. Birthplace Balto. Co, Md.

16 (a) Informant Mrs. Justine Jester
(b) Address 439 Hanover St.

17 (a) Burial (b) Date thereof 2/25/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western
Location Balto., Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 24 1944 (b) Huntington Williams, II
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-1944, at 6:15 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Due to
Other Conditions Multiple fractures, lacerations, contusions, abrasions, & burns
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-22-44 at 5 A M.
(b) Where did injury occur? Balt.-Fairfield Corp.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fell from Crane runway

23. Signature Howard J. Weesner M.D.
Medical Examiner.
Date signed 2-22-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

14397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 P

G 14397 Registered No.

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 E. Biddle St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Phyllis M. Gowan

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Divorced

6 (b) Name of husband Unknown

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 20th 1920

8. AGE: Years	Months	Days	If less than one day
23	5	3	hr. ..... min.

9. Birthplace Nashua N. H. (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business Hochschild Kohn Co.

FATHER
12. Name Arthur J. Gowan
13. Birthplace Nashua N. H.

MOTHER
14. Maiden Name Unknown
15. Birthplace N. H.

16 (a) Informant Mary Ricker
(b) Address 928 N. Calvert st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ (month) (day) 44 (year)
(c) Cemetery ~~or crematory~~ Mt Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st

19 FEB 24 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1944, at 3:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bichloride of mercury poisoning

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 22, 1944 M.
(b) Where did injury occur? 321 E. Biddle St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Swallowed Bichloride of mercury

23. Signature Robert Lee Yeatman M.D. Medical Examiner.
Date signed Feb. 23, 1944

VS 181

14398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G 14398
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Harwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Harwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Elizabeth T. Schwartz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27th 1874.

8. AGE: Years	Months	Days	If less than one day
69	11	26	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Gardner
11. Industry or business Self

FATHER
12. Name (Unknown) Schwartz
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Elizabeth T. Schwartz
(b) Address 604 Harwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23rd 1944, at 9:45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1937 to Feb 23 1944 and that I last saw him alive on Feb. 23 1944.

Immediate cause of death 1 Coronary Thrombosis — Duration 1 day

Due to Cardiac-renal-vascular disease — 7 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. N. Wilson
Address 617 N. 40 West Date signed 7/M 23/D 1944

14399 SPARKES

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 14399

Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 132 E. Oakland St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 132 E. Oakland St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary A. Sparkes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Chas W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1866

8. AGE: Years 77 | Months 3 | Days 29 | If less than one day: hr. min

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER

12. Name John Hunder

13. Birthplace Balto.

MOTHER

14. Maiden Name Mary

15. Birthplace Balto.

16 (a) Informant family

(b) Address 132 E. Oakland St.

17 (a) B. (Burial, cremation, or removal) **(b) Date thereof** 2/26/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Ritchie Highway

18 (a) Funeral director James R. McCarthy

(b) Address 130 E. Lanvale St.

19 (a) FEB 24 1944 (Date rec'd by registrar) **(b)** Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940. to Feb 23 1944

and that I last saw h alive on Feb 23 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 4 day

Due to arteriosclerosis

Due to

Other Conditions senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Mullen M.D.

Address 1st & Chester Sts. Date signed 2/24/44

M. D.

14400

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12 B

Registered No. 14400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Oliver St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Grace E. Kraft

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Clarence H.
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 3-21-87

8. AGE: Years	Months	Days	If less than one day
56	11	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Geo. Sipe
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth Moore
15. Birthplace Pa.

16 (a) Informant Family
(b) Address 1728 Jefferson St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 2-26-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ratcliffe Highway
18 (a) Funeral director Jas. McKinney
(b) Address 134 E. Fayette Ave.
19 (a) FEB 23 1944 (b) Livingston Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1944 at 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15/44 to 2/23/44 and that I last saw h[illegible] alive on 2/23/44

Immediate cause of death Tuberculous Meningitis

Duration

Due to

Due to

Other Conditions 1) Broncho-Pneumonia 2) Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas A. Finney M. D.
Address [illegible] Hosp. Date signed 2/24/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

G 14401

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 83a

G 14401
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antoinette Hoffman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name August Knipschild
13. Birthplace Germany

MOTHER
14. Maiden Name Betty Brockmann
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Rita Windfeld
(b) Address 914 Fremont Ave

19 (a) FEB 24 1944 (Date rec'd by registrar) Harrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 11 a.m.

20. DATE OF DEATH Feb. 23 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1- 1944, to Feb 23 1944, and that I last saw her alive on Feb-23 1944.

Immediate cause of death	Duration
Edema of Lungs -	2 days
Due to Cerebral Hemorrhage	23 "
Due to	
Other Conditions Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	5 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 2/24/44

G 14402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G 14402

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pier on foot of Clinton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Fort Lee
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 Main St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sven V. Porat

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alta Travis
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) April 19, 1899

8. AGE: Years	Months	Days	If less than one day
44	10	3	hr. min.

9. Birthplace Denmark
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name Christian Porat
13. Birthplace Denmark

MOTHER
14. Maiden Name Agnes Fabra
15. Birthplace Denmark

16 (a) Informant Alta Travis Porat
(b) Address 228 Main St. Ft. Lee, N.J.

17 (a) Cremation (b) Date thereof 2-25-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Newark, N.J.

18 (a) Funeral director A. Lee Ader
(b) Address 4644 York Rd.

19 (a) FEB 24 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22- 1944, at 11:10 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to Acute Congestive Cardiac Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maldeis M.D.
Medical Examiner.
Date signed 2-22-44

G 14403

VS 84328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G 14403 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 13
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 N. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ivolia Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1920

8. AGE: Years	Months	Days	If less than one day
23	6	21	hr min

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name William
13. Birthplace S. C.

MOTHER
14. Maiden Name Ada Stuedivent
15. Birthplace N. C.

16 (a) Informant B. C. Hosp. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

FEB 24 1944 (Registered) Huntington Williams Mfr

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/44 19.. at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13/44 19.. to 2/23/44 19.., and that I last saw h.. alive on 2/22/44.

Immediate cause of death Pulmonary T. B.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Helgen, M. D.
Address Balto. City Hosp. Date signed 2/23/44 M. D.

446944

G 14404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 14404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Barranquilla (If outside city or town limits, write RURAL and give town)
(d) Street No. Bvd. Sur-St 10-11 (If rural give location)
(e) Citizen of foreign country? Colombia (Yes or No) If yes, name country South American

3 (a) FULL NAME Ella Clausen de Escandon
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jose Antonio Escandon

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 10-29 1895

8. AGE: Years 48 | Months 3 | Days 24 | If less than one day: hr. min.

9. Birthplace S. A. (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Christian Peter

13. Birthplace Denm.

14. Maiden Name Carmen Cornejo

15. Birthplace S A

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1437 N Broadway

19 (a) FEB 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944 at 7 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1943 to Feb 23 1944 and that I last saw h[illegible] alive on Feb 22 1944

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Date signed 2-25-44

VS 150

(over)

G 14405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14405
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 S. Ellwood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 S. Ellwood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura E. Feehley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Michael J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1863

8. AGE: Years 80 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Henry Bensel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Harriett Ruby
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Hamer
(b) Address 805 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24, 1949 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Taylor Ave.

18 (a) Funeral director Claudine F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) FEB 24 1949 (Date rec'd by Registrar) (b) Huntingtown, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1949, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an enquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to Third degree burns, over chest, breast, forearms, neck, face, left

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 9 1949 at 3:P M.
(b) Where did injury occur? Home. 805 S. Ellwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Yes
(d) Means of injury Burned at home.

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 2/27/49

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 14406

Registered No. .....

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-9
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Paula Braitsch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 24, 1943

8. AGE: Years — | Months 8 | Days — | If less than one day: hr. ..... min .....

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John A. Braitsch
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dorothy E. Harchenhorn
15. Birthplace Baltimore

16 (a) Informant John A. Braitsch
(b) Address 1231 W Lombard St

17 (a) Burial (b) Date thereof 2-26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Whitelawn
Location Baltimore

18 (a) Funeral director Frederick A Cole
(b) Address 780 W Lombard St

FEB 24 1944
(Date rec'd by registrar)

(b) Huntington Williamsport Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1944 at 9:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular, Primary.

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

23. Signature W. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 2-24-44.

14407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14407

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 N. Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-0452

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1908

8. AGE: Years 35 ~~36~~ Months 9 Days 15 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter Wilson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Stanislawa Dzwarcek
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Emma Wilson
(b) Address 901 N. Lakewood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem.
Location Baltimore Md.

18 (a) Funeral director John H. Weber
(b) Address 1044 S. Chester Street

19 FEB 24 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1944, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pneumonia traumatic

Due to Fracture of skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 9 1944
(b) Where did injury occur? Baltimore Industrial Yard
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial place While at work? Yes
(d) Means of injury Fall at work

Signature Robert Lee Graham M.D. Medical Examiner.
Date signed February 23, 1944

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14408

B-86457

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45

G 14408
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1645 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ackille Derenzi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married-Separated

6 (b) Name of husband or wife Angeline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5-1887 ? or 1885 ?

8. AGE: Years	Months	Days	If less than one day
54?or 56 ?	8 7	18	hr. min

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Tailor (Retired)

11. Industry or business

FATHER
12. Name John Derenzi
13. Birthplace Italy

MOTHER
14. Maiden Name Antoinette Richard
15. Birthplace Italy

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave

19 (a) Filed 2 4 1944 (b) Recorded by registrar Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944 at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1944 to Feb 23 1944 and that I last saw h[illegible] alive on Feb 23 1944.

Immediate cause of death: Carcinoma of Jaw with metastasis — Duration: 9 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Balto City Hosp Date signed 2-24 1944

G 14409 Dumire G 14409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegheny
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Patterson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ray Dumire

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	None	M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6 1943

8. AGE: Years	Months	Days	If less than one day
	4	18	hr. min.

9. Birthplace Cumberland, Alle., Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ralph F. Dumire
13. Birthplace W Va

MOTHER
14. Maiden Name Ruby May McIntire
15. Birthplace W Va

16 (a) Informant Ralph F. Dumire
(b) Address

17 (a) Burial (b) Date thereof 2/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maple Grove
Location Hagerstown Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 129 E. Main St
19 (a) 2-24-1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1944, at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1944 to 2/24 1944, and that I last saw him alive on 2/24 1944.

	Duration
Immediate cause of death Heart Failure	Terminal
Due to Overwhelming Toxicity	2 days
Due to Pneumonia	1 week
Other Conditions Morphinism	over
(Include pregnancy within 3 months of death)	life

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at PM
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles A Simpson M. D.
Address University Hospital Date signed 2/24/44

G 14410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G 14410 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3613 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sadie G Pyles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Nicholas | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1887

8. AGE: Years 56 | Months 8 | Days 24 | If less than one day: hr. min.

9. Birthplace (Town, county, and state) Talbot Island Md

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas G Taylor
13. Birthplace Md

MOTHER
14. Maiden Name Georgianna Harrison
15. Birthplace Md

16 (a) Informant Mrs Margaret Entley
(b) Address 3613 Park Heights Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Londa Park
Location Baltimore Md

18 (a) Funeral director Tillman Funeral Dir
(b) Address 1217 E Fort Ave

19 (a) Date received by registrar FEB 24 1944 (b) Registrar's signature Livingston Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944, at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1944, to Feb. 23 1944, and that I last saw h-er alive on Feb. 23 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 24 hrs.

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis L Blum, M. D.
Address 3431 Park Heights Ave Date signed 2/24/44 M. D.

G 14411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14411 / 46M

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3505 N. Charles st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1804 Thomas Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lillie May Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Henry T. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30 1870

8. AGE: Years	Months	Days	If less than one day hr.	min.
73	2	23		

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER

12. Name George C. Hatton

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Mary Harris

15. Birthplace Balto. Md.

16 (a) Informant Mrs Albert Goldstein

(b) Address 3505 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25 1944 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) (b)

(Date received) (Registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1944 to Feb 23 1944, and that I last saw h alive on Feb 23 1944

Immediate cause of death

Cardiac Failure

Due to Coronary occlusion

Due to Arteriosclerosis

Other Conditions Coronary Sclerosis

G. I. Tract Malignancy ??

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Morris Faulcon, M. D.

Address 11 E. Chase St Date signed 2/24/44

G 14412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14412 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary B. Seeger

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John Seeger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG-16-1866

8. AGE: Years	Months	Days	If less than one day hr.	min.
77	6	7		

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Wade
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Kelly
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Abey J. Evans, Sons Inc
(b) Address 1184 N. Mt. Royal Ave

19 (a) FEB 24 1944 (Date received by registrar) (b) Interim for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION 9 4 m.

20. DATE OF DEATH Feb. 23 1944. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944. to Feb 23 1944. and that I last saw her alive on Feb 22- 1944.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 2-23-44

G 14413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14413
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days).

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Orleans St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Ritchie

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Margaret Ritchie
6 (c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) Jan. 18, 1871
8. AGE: Years: 73 | Months: 1 | Days: 5 | If less than one day: hr. min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: John Lewis Ritchie
13. Birthplace: Phila. Penna.

MOTHER
14. Maiden Name: Margaret E. Ritchie
15. Birthplace: Phila. Penna.

16 (a) Informant: Miss Mollie Wilson
(b) Address: 2852 W. North avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location:

18 (a) Funeral director: Chas J. Evans & Son
(b) Address: 118 N. Mt Royal Ave

19 (a) (Date received by registrar) (b) Huntington Ave Station, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1944, at 12:10 M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary edema

Due to: Constrictive pericarditis

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert L. Gutman M.D.
Medical Examiner.
Date signed Feb. 23, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB 1944

NS 451

G 14414

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14414
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1829 E Monument Ave
(c) Hospital or institution —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County —
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 1829 E Monument Ave. (If rural give location)
e Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Louis E. Krebs

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Late, Ebe L. Krebs
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1895
8. AGE: Years 48 | Months 5 | Days 11 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Police Guard
11. Industry or business Bath Hall Co. highway

FATHER
12. Name John W. Krebs
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Harriet L. Pascoe
15. Birthplace Petersville, Md.

16 (a) Informant Mrs. Lloyd E. Krebs
(b) Address 1014 W Barre Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 44 (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 3804 Frederick Avenue,

18 (a) Funeral director John F Cowan & Son
(b) Address 900 03 Baltimore Street

19 FEB 24 1944 (Date received by local registrar) Hunter for Williams, M.D.

0

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 22, 1944, at 8:24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1943 to 2/22 1944 and that I last saw him alive on 2/22 1944

Immediate cause of death
Tuberculosis of Lungs — Duration: 18 mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer L. Todd M. D.
Address 735 N Milton Ave Date signed 2/24/44

G 14415

G 14415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1677

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3016 Baker St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a. State Md. b. County

City or town Baltimore,
(If outside city or town limits, write RURAL and give town)

d. Street No. 3016 Baker St
(If rural give location)

e. Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bartholomew E. Naughton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1890

8. AGE: Years	Months	Days	If less than one day
53.	9	4	hr min

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Balto Transit Co

MOTHER / FATHER

12. Name Timothy E. Naughton

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary E. Walsh

15. Birthplace Baltimore Md

16 (a) Informant Miss Ella E. Naughton

(b) Address 3016 Baker St

17 (a) Burial (Burial, cremation, or removal) b. Date thereof 2/26/44 (month) (day) (year)

(c) Cemetery or crematory Mount Olivet Cem

Location 4300 Hartford Rd.

18 (a) Funeral director John F. Cowan & Son,

(b) Address 901-03 E. Fallsway

FEB 24 1944
(Date rec'd by registrar)

[illegible] Williams, M.D.
Registrar

VS 150

Approved: Robert E. Guthrie M.D. Feb. 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22nd 1944, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1944, to Feb 22 1944, and that I last saw him alive on Feb 22 1944.

Immediate cause of death Coronary Occlusion — Duration ?

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

c. Where did injury occur?
(City or town) (County) (State)

d. Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

e. Means of injury

23. Signature J. E. Schmidt M.D.

Address 2124 Brighton Date signed 2/23/44

G 14416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G 14416
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Margaret Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife ------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
Over 55 60 years			hr. min

9. Birthplace Texas, Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation Dress Maker
11. Industry or business

FATHER
12. Name Thomas Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Reagan
15. Birthplace Ireland

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Texas, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) ---- (Date rec'd by Registrar) (b) ---- Registrar

FEB 24 1944

Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944, at 8:13 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1936 to Feb 23 1944, and that I last saw her alive on Feb 16 1944.

Immediate cause of death: Coronary Thrombosis — Duration 1-2 hrs
Due to Cerebro-vascular accident — Duration Gradual
Due to Hypertension — Duration
Other Conditions: Diabetes Mellitus — Duration

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Hardy
Address 1403 Fairfax Date signed 2/24/44

Form 400

G 14417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 154

G 14417
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. yrs., mos., or days 1 day
(e) Length of stay in Baltimore yrs., mos., or days 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(d) Street No. 1021 N. Carey Street
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flowers

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr. February 17, 1944
8. AGE: Years Months Days If less than one day 8 hr 30 min
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Melvin I. Flowers
13. Birthplace Virginia

MOTHER
14. Maiden Name Beola Rusk
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 2 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) FEB 24 1944 (Date rec'd by registrar) (b) Registrar

VS 150

0751

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 19 44, at 01:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 17 19 44, to Feb. 18 19 44, and that I last saw him alive on Feb. 16 19 44.

Immediate cause of death ~~Prematurity~~ Atelectasis — Duration 8½ hrs.

Due to Prematurity — Duration 8½ hrs.

Due to Acute Yellow Atrophy of Mother — Duration 3 wks.

Due to Medical Therapy.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Fetal hepatitis

PHYSICIAN Underline the cause to which death should be charged (state cause)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Stephan, M.D.
Address Johns Hopkins Hospital Date signed 2-20-44

G 14418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14418 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 765 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C Phipps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1876

8. AGE: Years 67 Months 9 Days 11 If less than one day ? hr ? min

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John C. Phipps
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Amelia Stube
15. Birthplace Carrol Co. Md.

16 (a) Informant Mable A. Pumphrey
(b) Address 627 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/48 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Baltimore Md.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1112 Park Ave. Baltimore, Md.

(c) (Date received by registrar) (b) Registrar

FEB 24 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1948, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Burns, 2nd and 3rd. degree,

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following
(a) Date of injury 2-22-48 at 3 P.M.
(b) Where did injury occur? 765 W. Lexington St
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) No. if so, what?
(d) Means of injury Was intoxicated + upset an oil stove.

23. Signature W. L. Wollenweber M.D.
(Medical Examiner)
Date signed 2-24-48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G 14419
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 S. Monroe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wk
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 116 S Monroe Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME LAWRENCE CHARLES Snyder

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Elizabeth Snyder
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 24, 1882

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	—	—		

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Foreman
11. Industry or business: City of Baltimore

FATHER
12. Name: George Herman Snyder
13. Birthplace: ?

MOTHER
14. Maiden Name: Catherine Litchenberg
15. Birthplace: ?

16 (a) Informant: Mrs. Elizabeth Snyder
(b) Address: 116 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal): (b) Date thereof: 2-28-44 (month) (day) (year)
(c) Cemetery or crematory: U.S. Balto. National Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Avenue

19 (a) Date received by Registrar: FEB 27 1944 (b) Registered Number:

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1944, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1944, to Feb 24 1944, and that I last saw h[illegible] alive on Feb 23 1944.

Immediate cause of death Coronary Thrombosis — **Duration** 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Morris Bishrieder, M.D.
Address 3 E. Fulton Ave Date signed 2-24-44

G 14420

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14420
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3419 Fenwick Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
a. State Md. b. County
c. City or town Baltimore (If outside city or town limits, write Rural and give town)
d. Street No. 3419 Fenwick Road (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Elsie C. Haynes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife John H. Haynes
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 29, 1894

8. AGE: Years	Months	Days	If less than one day: hr.	min
49 50				

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Wm. S. Myers.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary E. Lilly.
15. Birthplace Maryland.

16 (a) Informant John H. Haynes.
(b) Address 3419 Fenwick Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Ehrlich & Donovan
b. Address 3615-17 Chestnut Ave

(b) Filed [illegible] Huntington Williams, M.D. Registrar

FEB 24 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1944. at 5 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939. to Feb 22 1944. and that I last saw he alive on Feb 21 1944.

Immediate cause of death Cerebral Hemorrhage. — Duration 8 days.

Due to Cardio-vascular renal disease & Hypertension. — 5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
a. Accident, suicide, or homicide
b. Date of occurrence at M
c. Where did injury occur? (City or town) (County) (State)
d. Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
e. Means of injury

23. Signature Ivan Donovan
Address 4646 W Belvedere Ave. Date signed 2/24/44

ASCo. 5-11 2M

G 14421 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 14421

CERTIFICATE OF DEATH

50

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 W 31st St St. Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Goldie M. DeCline

(a) Residence: No. 302 W 31st St St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE Stephen E. DeCline

6. DATE OF BIRTH (month, day, year) April 3 1896

7. AGE Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
47	10	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md.

FATHER

13. NAME Elisha Thomas

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Laura J. E. Lloyd

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Stephen E. DeCline
(Address) 302 W 31st St

18. BURIAL, CREMATION, OR REMOVAL
Place Baltimore Date Feb 25 19 44

19. UNDERTAKER Edmonds & Sommers
(Address) 3615-17 Edmondson Ave.

20. FILED FEB 24 1944 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 23, 1944

22. I HEREBY CERTIFY, That I attended deceased from 9/4/43, 19..., to 2/23, 1944

I last saw her alive on 2/22 1944 death is said to have occurred on the date stated above, at 12:25 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma R. Breast	1941
Metastasis to L. Breast.	
" " Liver.	
R. Breast was removed.	
Other contributory causes of importance:	

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? NA If so, specify .....

(Signed) [signature] M. D.

(Address) 2020 E. Eager Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 14422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14422

Registered No. 52B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 months 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 Main St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Eastwood, Mr Charles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1864

8. AGE: Years	Months	Days	If less than one day
80	0	16	hr min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Coppersmith
11. Industry or business

FATHER
12. Name Edward Eastwood
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden Name Sara —
15. Birthplace Philadelphia

16 (a) Informant Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery or crematory Portsmith Virginia
Location

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave Huntington Hollands, Md.

19 (a) (Signature of registrar) Registrar

FEB 24 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1943 to Feb 24 1944, and that I last saw him alive on Feb 24 1944.

Immediate cause of death	Duration
Bronchial Pneumonia	?
Due to Chronic Nephritis	?
Due to Bladder Epithelioma	?
Due to Benign Prostatic Hypertrophy	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Oct 27 1943
Major findings of operation: Epithelioma of Bladder, Benign Prostatic Hypertrophy
of autopsy: None done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Geller M. D.
Address Church Home & Hosp Date signed 2-28-44

G 14423 G 14423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Lime mill Rd., Owings Mills (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Rainey

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband John Rainey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1901

8. AGE: Years	Months	Days	If less than one day
42	10	26	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Pickering
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Wright
15. Birthplace Md.

16 (a) Informant Husband
(b) Address Lime mill Rd. Balti. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. View Cathedral
Location 3900 Old Frederick Rd

18 (a) Funeral director Harry F. Wilkes
(b) Address 4101 Edmondson Ave

19 (a) 1944 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1944, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1944 to 2-22 1944 and that I last saw h[illegible] alive on 2-22 1944.

Immediate cause of death	Duration
Uremia	
Due to Anemia	
Due to Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. A. Ingram M. D.
Address Univ. Hospital Date signed 2/24/44
Balt. Md

14424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C 14424

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 811 Whitelock St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-2

(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 811 Whitelock St (If rural give location)

(e) Citizen of foreign country? (Yes or No) No

If yes, name country

3 (a) FULL NAME Leba Mervis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-6-2

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name

13. Birthplace Russia

MOTHER — 14. Maiden Name

15. Birthplace Russia

16 (a) Informant Mrs. Samuel M. Rindlet

(b) Address 3509 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt. Carmel

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto. St

(a) (b)

FEB 25 1944 (Date received by registrar) Hunington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1944 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 19 to 2-23 1944 and that I last saw h alive on 2-22-44 19

Immediate cause of death

Coronary Arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address 904 Rent. Rd. Date signed 2/25/44 M.D.

14425 BENDEN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. C 14425

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2246 Guilford Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2246 Guilford ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Leroy L. Benden

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Baby —

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 4/7/1943

8. AGE: Years	Months	Days	If less than one day
	10	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Richard Benden
FATHER 13. Birthplace —

MOTHER 14. Maiden Name Benden B. Keefe
MOTHER 15. Birthplace Pennsylvania

16 (a) Informant Mrs L Benden
(b) Address 2246 Guilford Ave

17 (a) Burial — (b) Date thereof 2 25 1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location —

18 (a) Funeral director Mary M Woodfield
(b) Address 501 E 22nd St

19 (a) Huntington Williams, M.D. Registrar
(Date received by Registrar) FEB 25 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944 at 7P M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 15 1944 to Feb 23 1944 and that I last saw h— alive on Feb 23 1944

Immediate cause of death Lobar Pneumonia — **Duration**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Ephraim M. D.
Address 4436 Erdman Ave Date signed 2-24-44

14426

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

447067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14426
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPIT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4 Wakefield Ct. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Wakefield Ct. Rural Home (If rural give location)
(e) Citizen of foreign country? Alex. Va. (Yes or No) If yes, name country

3 (a) FULL NAME John J. Orr
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Dorothy Orr
6 (c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) 1899
8. AGE: Years 45 | Months | Days | If less than one day: hr. min.
9. Birthplace: Mich. (Town, county, and state)
10. Usual Occupation: manufacturer
11. Industry or business

FATHER
12. Name: Frank Orr
13. Birthplace: Mich.

MOTHER
14. Maiden Name: Katherine McCommon
15. Birthplace: Ohio

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPIT

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 28 1944 (month) (day) (year)
(c) Cemetery or crematory
Location: Alexandria Virginia

18 (a) Funeral director: J S Ewell.
(b) Address: Alexandria, Va.

FEB 25 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1944 at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1944 to Feb 24 1944, and that I last saw him alive on Feb. 24 1944.

Immediate cause of death: Respiratory Failure — Duration: 4 mos.

Due to: Metastatic carcinoma. — Duration: 4 mos.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Orr M.D.
Address Date signed 2-24-44

12427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G 14427
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5312 Brabant Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 → 4
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5312 Brabant Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MAY BURKART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Otto J.N.Burkart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th, 1874

8. AGE: Years 69 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ferdinand Hahn
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Schild
15. Birthplace Germany

16 (a) Informant Mr. Otto J.N.Burkart,
(b) Address 5312 Brabant Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Feb. 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto., Md.

18 (a) Funeral director Penna. Funeral Home
(b) Address 7401 Belair Road

19 (a) FEB 25 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22nd, 1944, at 8:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 - 1943 to 2-22 1944 and that I last saw her alive on 2-22 1944

Immediate cause of death: Congestive Heart Failure — Duration: 3 days

Due to: Essential Hypertension — 12 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nahum K. Gallagher M.D.

Address Catonsville, Md. Date signed 2-24-44

14428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G 14428 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 834 S. Ponca St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 S. Ponca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ann Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1942

8. AGE: Years	Months	Days	If less than one day
2	-	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Elton Jones
13. Birthplace Cape Charles, Virginia

MOTHER
14. Maiden Name Olive Lewis
15. Birthplace Morgan Town, West Virginia

16 (a) Informant Olive Jones
(b) Address 834 S. Ponca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cemetery
Location Eastern Avenue Road

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

FEB 25 1944 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1944, to Feb 23, 1944, and that I last saw h[illegible] alive on Feb 23, 1944.

Immediate cause of death: Acute Bronchio-Pneumonia — Duration 1 day
Due to Acute Nephritis
Due to —
Other Conditions —
(Include pregnancy within 3 months of death) Hydrocephalus.
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Glass M. D.
Address 976 Wallace St. Date signed 2/24/44

14429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 14429 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 S. Dallas st
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 S Dallas st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WLADYSLAW SKORUPA OR WALTER SKORUPA

3 (b) If veteran, name war: WORLD WAR I
3 (c) Social Security Account No. 213-09-9538

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 [illegible] 1887

8. AGE: Years	Months	Days	If less than one day
57 56 ?			hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Tailor = PAUL SOJKA
11. Industry or business T/A Maryland Pants Contractor

FATHER
12. Name Vincent Skorupa
13. Birthplace Poland

MOTHER
14. Maiden Name Magdalena ?
15. Birthplace Poland

16 (a) Informant FELIX SKORUPA
(b) Address 116 South Wolfe st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Ann st.

Filed 2-25-1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23rd 1944, at 10[illegible] P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1944 to Feb. 23 19 44 and that I last saw h[illegible] alive on Feb. [illegible] 19 44

Immediate cause of death: Cardiac Failure
Pneumonia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: over

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 25 [illegible] Eutaw Date signed 2/24/44 M. D.

G 14430 GRAY ✓ G 14430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Aisquith st (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary R. Gray
3 (b) If veteran, name of war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband Zachariah Gray
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 24 1858
8. AGE: Years 85 | Months 4 | Days 0 | If less than one day hr. min.
9. Birthplace Anne Arundel Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Boyd
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Gertrude Mack
(b) Address 1537 Aisquith St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.
18 (a) Funeral director William Cox Inc
(b) Address 1807 St. Paul St.
19 (a) (Date rec'd by registrar) FEB 23 1944 (b) Huntington Williams Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1944 at 12 30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1944 to 2-24 1944, and that I last saw her alive on 2-24 1944.

Immediate cause of death: Myocarditis + endocarditis — Duration: 6 wks
Due to: Generalized arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. L. Gordy per Gabriel M. D.
Address 5706 Harford Rd Date signed 2-24-44

G 14431
#49794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12B

G 14431
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Ridgeley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Reed
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary Reed
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, y) May 10 1911

8. AGE: Years	Months	Days	If less than one day
32	9	14	hr. min

9. Birthplace Md. (Chesapeake City)
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Chas. T. Brandt Inc

FATHER
12. Name Joseph Reed
13. Birthplace Delaware

MOTHER
14. Maiden Name Laura Shahan
15. Birthplace Delaware

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) Date rec'd by local reg. (b) Name of local reg. Huntington Md. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1944 at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1944 to Feb. 24 1944 and that I last saw him alive on Feb. 24 1944.

Immediate cause of death: Lobar pneumonia — Duration

Due to: pneumococcus type 25

Due to:

Other Conditions: ?? pulmonary thr
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Bumingham M.D.
Address JHH Date signed 2-27

G 14432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14432 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address No. N. Broadway
(c) Hospital or institution: Church Home & Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Towson, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Washington Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Silk Also Known as MARY CATHERINE TARBERT

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Andrew Jackson Tarbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1871

8. AGE: Years	Months	Days	If less than one day
72	2	14	/ hr / min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Isaac La Rue
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Allison
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Maria Cem.
Location Towson, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 1944 Balto., Md.

FEB 25 1944
19 (a) (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1944, to Feb. 23 1944, and that I last saw her alive on Feb 22 1944.

Immediate cause of death hemiplegia — Duration

Due to arteriosclerotic & hypertensive cardiovascular disease

Due to

Other Conditions Terminal bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Dr. Rhoads

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Cullen M. D.
Address Church Home & Hosp Baltimore Md. Date signed 2-23-44

14433

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1190

G 14433
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 + 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 6731 Dogwood Rd (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence Harvey (LAWRENCE VERNON HARVEY)

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife ---
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/21/43
8. AGE: Years -- Months 2 Days 2 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Lawrence Harvey
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Dorothy Marr
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Dorothy Harvey
(b) Address 6731 Dogwood Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 25 1944 (Date received by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1944, at 7[40] P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19.. to 19.., and that I last saw h alive on 19..

Immediate cause of death: Respiratory failure

Due to: Diarrhea

Due to: Pregnancy complicated by bilateral bronchial pneumonia

Other Conditions (Include pregnancy within 3 months of death)

Duration: 1 wk. 1 wk.

Date of operation

Major findings of operation:

of autopsy: Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh G. Power Jr. M. D.
Address Date signed

14434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14434
Registered No.

131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3122 Berkshire Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 Berkshire Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Moritz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed~~ ~~divorced~~

6 (b) Name of husband or wife Mary M. Moritz
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) 6/14/1860

8. AGE: Years 83 | Months 8 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Furniture.

FATHER
12. Name Albert Moritz
13. Birthplace Düsseldorf, Germany

MOTHER
14. Maiden Name Don't Know
15. Birthplace Germany

16 (a) Informant Melvin L. Moritz
(b) Address 3132 Berkshire Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director George W. Schilling & Son
(b) Address 3624 Greenmount Ave.

19 FEB 25 1944 (Date rec'd by Registrar) (b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944, at 7, M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1942 to Feb 23 1944, and that I last saw h[illegible] alive on Feb 23 1944.

Immediate cause of death	Duration
Myocardial Insufficiency	10 min.
Due to Arteriosclerosis	10 yrs.
Due to Chronic Nephritis	5 yrs.
Other Conditions General weakness	—

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest L. Zimmerman M. D.
Address 9935 Harford Rd Date signed 2-24-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 B

Registered No. G 14435

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2758 Fenwick Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2758 Fenwick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V Lomax

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 8 1884

8. AGE: Years	Months	Days	If less than one day
59	10	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Francis H Lomax
13. Birthplace Md

MOTHER
14. Maiden Name Almira C Jackson
15. Birthplace Md

16 (a) Informant Mrs Annie Walmsley
(b) Address 1659 Rabworth Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director William M Moreck
(b) Address 715 Light St

19 (a) FEB 25 1944 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944, at 2.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1942 to Feb 23 1944, and that I last saw her alive on Feb 23 1944.

Immediate cause of death: Myocardial Insufficiency — Duration 24 hrs
Due to Pneumonia — 24 hrs
Due to Grippe — 96 hrs
Other Conditions General debility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw. L. Zimmerman M. D.
Address 9858 Maryland Date signed 2-24-44

G 14436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14436 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A.A.
(c) City or town Cedar Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. R. Tobie Highway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Rose Lutz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9. 1878

8. AGE: Years	Months	Days	If less than one day
65	4	9 12	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER 12. Name Harman G Bredekamp

13. Birthplace Md

MOTHER 14. Maiden Name Mary R Shadtman

15. Birthplace Md

16 (a) Informant John Lutz

(b) Address R. Tobie Hgt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Brooklyn Md

18 (a) Funeral director William M Mareck

(b) Address 715 Light St

19 (a) FEB 25 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1944, at 10 15 P M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Thoracic Hemorrhage

Due to Fractured ribs

Other Conditions Fract. 7th dorsal vertebra multiple lacerations abrasions & bruised burns

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/5

(a) Date of injury 2-21-44 at 9.35 P M.

(b) Where did injury occur In front of 3717 Hanover St

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Struck by an automobile

23. Signature Howard J. Mendelsohn M.D. Medical Examiner.

Date signed 2-22-44

VS 151

Please write plainly, with pen and ink. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

14437 [illegible]027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G 14437 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo-6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

17-3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Deskins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/[illegible]

8. AGE: Years	Months	Days	If less than one day
52	10	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Cleaning
11. Industry or business

FATHER
12. Name Jake Monroe
13. Birthplace ?

MOTHER
14. Maiden Name Carrie Ballard
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 922 N. Schroeder St.

19 FEB 25 1944 [illegible] Registrar
(Date rec'd by registrar)

VS 150

0

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23-44 19 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1944 to 2-23 1944, and that I last saw h[illegible] alive on 2-23 1944.

Immediate cause of death

	Duration
Gen Peritonitis	1 mo
Due to Probable Salpingitis	7
Due to Uterine Fibroids	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1-20-44
Major findings of operation: Fibroid uterus
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald Bzleb M. D.
Address Balto City Hosp Date signed 2-24-44

G 14438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G 14438

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1530 Homestead St

(c) Hospital or institution: at Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 1530 Homestead St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Guidice

3 (b) If veteran, name war: no

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie V. Guidice (nee Plowman)

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan 24 1877

8. AGE: Years 67 | Months 0 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Fireman, Baltimore

11. Industry or business City Fire Department

FATHER 12. Name John Guidice

13. Birthplace Germany

MOTHER 14. Maiden Name Not Known

15. Birthplace Germany

16 (a) Informant Mrs Annie V. Guidice

(b) Address 1530 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26/44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cemetery

Location 2930 Frederick Road

18 (a) Funeral director Edmund W. Conklin & Son

(b) Address 924 E. Eager St.

FEB 25 1944 (Date of death) (year) (b) Huntington (Williams), W. Va. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23rd 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21, 1944 to Feb. 23, 1944 and that I last saw h alive on Feb. 23, 1944.

Immediate cause of death	Duration
Acute Myocardial Failure	1 hour
Due to Chronic Myocarditis	2 years
Due to	
Other Conditions Chronic Bronchitis	5 years

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ✓

(b) Date of occurrence ✓ at ✓ M

(c) Where did injury occur? ✓ (City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? (Specify type of place)

(e) Means of injury ✓

23. Signature Frank H. Updegrove M. D.

Address 2701 N. Calvert. Date signed Feb. 24/44

G 14439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14439 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 Woodington Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Woodington Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATE TOWHEY

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: DENIS TOWHEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1854

8. AGE: Years 89 | Months — | Days — | If less than one day: hr. min. 90

9. Birthplace IRELAND (Town, county, and state)

10. Usual Occupation

11. Industry or business NONE

FATHER
12. Name UNKNOWN
13. Birthplace IRELAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace IRELAND

16 (a) Informant CATHERINE TOWHEY
(b) Address 609 Woodington Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1944 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location Baltimore Md

18 (a) Funeral director Holt & B. M. Walter
(b) Address PRATT & STRICKER STS

19 FEB 25 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1944 at 6 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1944, to Feb. 23 1944, and that I last saw her alive on Feb. 23 1944.

Immediate cause of death	Duration
Cardiac paralysis	1 week
Due to Angina pectoris	2 weeks
Due to Hypertension	1 year
Other Conditions Myocarditis	2 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Johnson Pound M. D.

Address 2 W. Read St Date signed 2/24/44

G 14440

AB-86606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 14440 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 151
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs-40 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Balmor Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Lightfoot

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hattie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24-1889

8. AGE: Years 54 | Months 6 | Days 30 ?? | If less than one day hr min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Lightfoot
13. Birthplace N.C.

MOTHER
14. Maiden Name Betty ?
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (month) (day) (year)
(c) Cemetery or crematory Hertford N. C
Location North Carolina

18 (a) Funeral director Wm. B. Nelson
(b) Address 1303 Preastman St

19 (a) Date received by Registrar FEB 25 1944 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1944, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1944 to 2-23 1944, and that I last saw h[illegible] alive on 2-23 1944.

Immediate cause of death Pneumonia — Duration 2 days

Due to Lobar pneumonia — 11 days

Due to ? Bronchitis — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Hebbe

Address B.C.H. Date signed 2/24/44 M.D.

G 14441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92

Registered No. G 14441

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 Bruce Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Bruce Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha E. Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	married

6 (b) Name of husband or wife James Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1914

8. AGE: Years	Months	Days	If less than one day
29	4	27	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name George Tyree
13. Birthplace md

MOTHER
14. Maiden Name Mary Swanson
15. Birthplace md

16 (a) Informant James Johnson
(b) Address 1609 Bruce Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Lloyd G. Nelson
(b) Address 303 Pennsylvania Ave

19 (a) FEB 25 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1944, at 10 32 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 19 44 to Feb 21 19 44, and that I last saw h[illegible] alive on Feb 21 19 44.

Immediate cause of death (a) B. Cerebral Embolism — Duration: 24 hours
Due to
Due to
Other Conditions Valvular heart disease — Duration: Unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Wadell M. D.
Address 561 Hamilton Ave Date signed 2/24/44

G 14442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G 14442

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1233 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Athenia Marks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1943

8. AGE: Years	Months	Days	If less than one day
	9	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Woodson Marks
FATHER 13. Birthplace Va.

MOTHER 14. Maiden Name Ethel Jones
MOTHER 15. Birthplace Md.

16 (a) Informant Ethel Marks
(b) Address 1233 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Mrs Roberts-Elliott Dft
(b) Address 1129 N. Carlton St.

19 FEB 25 1944 Hunting for Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1944, at 4 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1944 to Feb. 22 1944 and that I last saw h e r alive on Feb 19 1944

Immediate cause of death Lobar Pneumonia — Duration 10 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warren H. C. Lake M. D.
Address 1501 E. Eager St. Date signed 2/25/44

14443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131C

G 14443

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1416 E Preston St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Betty Hackaday

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 19 44, at 11:30P. M

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sept 1, 1891
8. AGE: Years 52 Months 5 Days 22 If less than one day hr. min.
9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry Oneill
13. Birthplace N.C.

MOTHER
14. Maiden Name Laura Harrison
15. Birthplace N. C.

16 (a) Informant Nettie Stokes
(b) Address 1746 E Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location U.G. County Md.

18 (a) Funeral director Mrs Robert A Ellis
(b) Address 1249 N. Carlton St.

19 (a) FEB 25 10 A (Date rec'd by registrar) (b) ..... Registrar

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH ..... Uremia

Due to Chronic parenchymatous nephritis

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? .....
(d) Means of injury .....

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 2-24-44.

VS 151

G 14444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

Registered No. G 14444.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ollie Earl Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17th 1943

8. AGE: Years	Months	Days	If less than one day
	4	5	hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Ollie Battle
13. Birthplace Hamlet N.C.

MOTHER 14. Maiden Name Pattie Johnson
15. Birthplace Petersburg Va

16 (a) Informant Ollie Battle
(b) Address 1220 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25-1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Balto. Md.

18 (a) Funeral director Bylsma Hamill & Wright
(b) Address 710 Eutaw St

19 (a) FEB 25 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1944, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 10/2 P.
(a) Date of injury February 22, 1944 1:30 P.M.
(b) Where did injury occur? 1220 E. Madison
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Burned in conflagration

23. Signature Robert A. Fisher M.D. Medical Examiner.
Date signed Feb. 24, 1944

VS 151

Please write plainly, with ONE ENTRY in each space. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14445

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph Hospital 127
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Oakenshaw
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Estella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-1866

8. AGE: Years 77 Months 7 Days 20 If less than one day hr min

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Conductor P. R.R. (Retired)

11. Industry or business

FATHER 12. Name John Dobson

13. Birthplace Ireland

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Mrs. H. Reuter

(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-28-44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto Co. Md

18 (a) Funeral director Leonard J. Keogh

(b) Address 5734 Harford Rd

19 FEB 25 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1944 at 6.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1944 to Feb 24 1944, and that I last saw him alive on Feb. 24 1944.

Immediate cause of death: Acute myocardial failure — Duration

Due to: Arteriosclerotic C.V. disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. F. Reckties

Address St. Joseph Hosp. Date signed 2/25/44

G 14446
447323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55E

G 14446
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 460 E Kerneway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Lyons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-14

8. AGE: Years	Months	Days	If less than one day
29	4	8	hr. min.

9. Birthplace Md Ireland (Town, county, and state)
10. Usual Occupation Childs Nurse
11. Industry or business

MOTHER / FATHER
12. Name Michael Lyons
13. Birthplace Ohio Ireland
14. Maiden Name Margaret Dolan
15. Birthplace Ohio Ireland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Rucker
(b) Address 5305 Harford Rd.

19 (a) FEB 25 1944 (Date rec'd by registrar) (b) Huntington Hitt Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944 at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1944 to Feb 23 1944
and that I last saw her alive on Feb 28 1944

Duration
1½ yrs

Immediate cause of death Hemorrhage

Due to Lymphosarcoma

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Barton Wright M. D.
Address Johns Hopkins Date signed 2-27

G 14447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 14447
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 S. CURLEY ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD. (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 S. CURLEY ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ELISE NEUMANN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: MAX NEUMANN

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JAN. 26 1854

8. AGE: Years 90 | Months 0 | Days 29 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: UNKNOWN
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: GEORGE R. NEUMANN (SON)
(b) Address: 103 S. CURLEY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 28/44 (month) (day) (year)
(c) Cemetery or crematory: WESTERN CEM.
Location: EDMONDSON AVE.

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S. WOLFE ST.

19 (a) Date received by registrar: FEB 25 1944
VS 188

Registrar: Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEB. 24 1944, at 3/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1944 to Feb 24 1944 and that I last saw [illegible] alive on Feb 24 1944.

Immediate cause of death: Exhaustion — Duration: 2 Days

Due to: arteriosclerosis — Duration: indef.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: R. L. Campbell

Address: 1644 Hanover St. Date signed: 2/25/44

G 14448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14448 Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city limits, write RURAL and give town)
(d) Street No. 707 N. Santoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alex Holiday

3 (b) If veteran, name war

3 (c) Social Security Account No. 251-14-1437

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Fannie May Holiday.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years	Months	Days	If less than one day
20			hr. min.

9. Birthplace Sumter S. Carolina (Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business Maryland Sanitary Corp.

FATHER
12. Name Paul Holiday
13. Birthplace Sumter S. Carolina

MOTHER
14. Maiden Name Claudy Wells.
15. Birthplace Sumter S. Holiday.

16 (a) Informant Mary Max
(b) Address 707 N Santoga St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 2 (month) 25 (day) 44 (year)

(c) Cemetery or crematory Sumter S. Carolina
Location South Carolina

18 (a) Funeral director Walter S. Bragg
(b) Address 130 W. Hamley St.

19 (a) 1944 (Must be rec'd by registrar) (b) Huntington Wilson Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21-44 1944 at 1:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1944 to 2-21 1944, and that I last saw h[illegible] alive on 2-21 1944

Immediate cause of death Pneumonia and cardiac failure — Duration

Due to Tuberculous peritonitis

Due to

Other Conditions Pulmonary and glandular tuberculosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. M. Jones M. D.
Address Univ. Hosp. Date signed 2/22/44

G 14449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14449 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3411 Bateman Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3411 Bateman Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond K. Rice

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Edith McDonald Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1876

8. AGE: Years	Months	Days	If less than one day
67	7	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Salesman, coal business
11. Industry or business

FATHER
12. Name John Wade Rice
13. Birthplace Unknown

MOTHER
14. Maiden Name Sophia Mantz
15. Birthplace Unknown

16 (a) Informant Edith McDonald Rice
(b) Address 3411 Bateman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 26, '44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ellsworth Director
(b) Address 3911 Liberty Hghts. Ave.

19 (a) (Filled in by registrar) (b) Registrar

FEB 25 1944
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1944 at 2.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6, 1937 to Feb 23, 1944 and that I last saw h alive on Feb 23, 1944

Immediate cause of death Coronary Thrombosis with Chronic Myocarditis — Duration 7 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M B Levin MD
Address 211 W. Monument St Date signed 2/27/44

G 14450 — Groemer — G 14450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 W. Lombard (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John W^m. Groemer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: W Unit

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eva Clark

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Aug 20. 1889

8. AGE: Years: 54 | Months: 6 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual Occupation: Contracting Engineer

11. Industry or business: Oil fields

FATHER
12. Name: Henry Groemer
13. Birthplace: Balto Md

MOTHER
14. Maiden Name: Elizabeth Neubert
15. Birthplace: Balto Md

16 (a) Informant: Mrs Joe Meehan
(b) Address: 115 N. Bentalou

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Old Frederick Rd

18 (a) Funeral director: Thos J Kenny
(b) Address: Hollins & Calhoun

19 (a) 2-25-1944 (b) [illegible] Registrar.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Rupture of Heart

Due to: Coronary thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert Lee Graham M.D. Medical Examiner.

Date signed: Feb 23 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 14451 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2631 Easetern Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2631 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILHELMINA TIEDEBOHL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles J. Tiedebohl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1857

8. AGE: Years	Months	Days	If less than one day
86	9	20	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Anne E.
13. Birthplace Germany

MOTHER
14. Maiden Name Henry J. Jerscheid
15. Birthplace Germany

16 (a) Informant Mrs. Catrie Byrne
(b) Address 2631 Eastern Ave.

17 (a) Burial (b) Date thereof 2/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory First United Evan.
Location Baltimore, Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) FEB 25 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1944, at 4:05 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Aug. 1 1943 to Feb 24 1944, and that I last saw h er alive on Feb 24 1944.

Immediate cause of death	Duration
Senile Arteriosclerosis	5 yrs.
Due to Old age	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Volentine M.D.
Address 4827 Reisterstown Date signed 2/25/44

G 14452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22a

G 14452 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 LORMAN Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HAGAN, Gordon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1942

8. AGE: Years	Months	Days	If less than one day
1	3 2	1 8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Raymond Hagan
13. Birthplace Wilson, N. C

MOTHER
14. Maiden Name Beulah Micqlotten (?)
15. Birthplace Baltimore

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-44 (month) (day) (year)
(c) Cemetery or crematory Alpharetta Mem. Park
Location Balto. Co., Md.

18 (a) Funeral director Mrs. Florence A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Date received by Registrar FEB 25 1944
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1944, at 3 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1944, to Feb 24 1944, and that I last saw h[illegible] alive on Feb 24 1944.

Immediate cause of death meningitis — Duration 7

Due to probable tuberculosis

Due to prob. miliary tbc

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed 2-25

G 14453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14453 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3035 Guilford Ave
(c) Hospital or institution: At Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3035 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Weipert

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John C. Weipert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4th 1855

8. AGE: Years 88 | Months 2 | Days 19 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Home Work at Home

11. Industry or business

FATHER 12. Name Joseph Suess
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Furst
15. Birthplace Germany

16 (a) Informant Mrs Zeller Richard J.
(b) Address 3035 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26, 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemy
Location 4430 Belair Road

18 (a) Funeral director Elmer W. Conklin Son
(b) Address 924 E. Eager St.

19 (a) FEB 25 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23rd 1944, at 2.35 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943, to 2/23 1944, and that I last saw her alive on 2/23 1944.

Immediate cause of death Arteriosclerotic cardio renal disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, or place)
(e) Means of injury

23. Signature John G. Magruder M. D.
Address 1445 N Gay St Date signed

G 14454 — Lilly Newton — G 14454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Dallas Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lilly Newton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Isaac Newton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
47 46			hr. min.

9. Birthplace Atlanta, Ga. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wesley Williams
13. Birthplace Ga.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Isaac Newton
(b) Address 102 S. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date received by registrar) FEB 25 1947 (b) Registrar Houston Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22- 1947, at 11:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andrews M.D. Medical Examiner.
Date signed 2-23-47

G 14455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14455 Registered No. 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Ruzicka

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age 7-1859

7. Birth date of deceased (mo., day, yr.) July 24, 1896

8. AGE: Years	Months	Days	If less than one day
84 ~~87~~	6 ~~11~~	26 ~~16~~	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Retired

FATHER
12. Name Joseph Ruzicka
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Jerom
15. Birthplace Austria

16 (a) Informant Frederick Ruzicka M.D.
(b) Address 2300 Edmondson Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-26-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brockton
(b) Address 900 N. Gilmor St, Baltimore, M.D.

19 (a) (Date received by registrar) (b) Registrar

FEB 25 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23-1944 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1943 to Feb 23 1944 and that I last saw h alive on Feb 2 - 1944.

Immediate cause of death	Duration
Cardio Vascular	
Due to Diseased Arteriosclerosis	
Due to Acute Cardiac Dilatation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick Ruzicka M.D.
Address 2300 Edmondson Ave Date Signed 2-25-44

(over)

G 14456 — JL - 80315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

G 14456 — Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 - 11
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Armstrong

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Alma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1902

8. AGE: Years	Months	Days	If less than one day
42	0	23	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation ?
11. Industry or business Canton Lumber Co- Boston St.

FATHER
12. Name Charles Armstrong
13. Birthplace N. C.

MOTHER
14. Maiden Name Henrietta Mann
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-44 (month) (day) (year)
(c) Cemetery or crematory Elizabeth City N. C.
Location N. C.

18 (a) Funeral director Wes. D. Nelson
(b) Address 1303 Presstman St.

FEB 25 1944 (Date filed by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28/44 19 , at 2 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12/43 19 , to 2/23/44 19 , and that I last saw him alive on 2/22 19 44.

Immediate cause of death Miliary T.B.

Due to Bilateral caseous chronic pneumonic T.B.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Miliary T.B -

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Acton, M.D.
Address Balto. City Hosp. Date signed 2/28/44 M. D.

G 14457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14457 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 Allendale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Allendale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Wetzelberger

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frederick A. Wetzelberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 13, 1870

8. AGE: Years	Months	Days	If less than one day
74	0	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Peter Weigert
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. James W. Nickerson
(b) Address 107 Allendale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore, Md.

18 (a) Funeral director Miller Lamoreux
(b) Address 4510 Liberty Heights Ave.

FEB 25 1944 (Date rec'd by registrar) (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1944, at 3.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1943 to 2/23 1944. and that I last saw her alive on 2/23 1944.

Immediate cause of death: Chronic Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin H. Evanston M. D.
Address 4209 Frederick Ave. Date signed 2/25/44

G 14458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14458 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 E. 37th St.
(c) Hospital or institution: 9 B
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 E. 37th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Stees

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband or wife John O. Stees

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1859.

8. AGE: Years	Months	Days	If less than one day
84	10	14	hr min.

9. Birthplace Marysville Pa (Town, county, and state)

10. Usual Occupation Home

11. Industry or business Sick

FATHER
12. Name John Christ
13. Birthplace Marysville Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa.

16 (a) Informant M. G. Stees
(b) Address York Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Chestnut Grove
Location Marysville Pa

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 25 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23rd 1944, at 11 a.m. M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 1st 1944 to Feb 23 1944, and that I last saw h[illegible] alive on Feb. 23. 1944.

Immediate cause of death — Duration

Due to Acute Dilatation of Heart — Four minutes

Due to Chronic Myocarditis — years

Other Conditions Old age

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Lee Blake M. D.
Address Med Arts Bldg Date signed

G 14459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B Registered No. G 14459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fremden & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Evesham Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Jane C Hoskall

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Vernon

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 27 1895

8. AGE: Years	Months	Days	If less than one day
47	4	2	9 hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Woman Wife

11. Industry or business none

FATHER
12. Name Lawrence Latter
13. Birthplace Md

MOTHER
14. Maiden Name Martha Lee
15. Birthplace Md

16 (a) Informant Vernon C Hoskall
(b) Address 705 Evesham Ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 2/28/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director William Lowndes
(b) Address 1219 W Lanvale St

19 (a) 2 D 25 1944 (Date received by registrar) **(b)** Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25/44 19 ..., at 6 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1944, to 2/25 1944, and that I last saw h[illegible] alive on 2/25 1944.

Immediate cause of death Carcinoma of bladder & metastasis.

Duration

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature William A. Mitchell M.D. M. D.

Address Bal. Gen. Hosp. **Date signed** 2/25/44

VS 2

G 14460
449568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 89a

G 14460
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 8239 EASTERN AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Ronald Lee Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 - 7 - 43

8. AGE: Years	Months	Days	If less than one day
	11	15	hr min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation CHILD
11. Industry or business

MOTHER / FATHER
12. Name John Smith
13. Birthplace W. Va.
14. Maiden Name Tressie Marth
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave.

18 (a) Funeral director John H Connelly
(b) Address 418 Eastern ave.

19 FEB 26 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1944 at 1:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1944 to Feb 22 1944 and that I last saw him alive on Feb 22 1944

Immediate cause of death	Duration
Septic sinus thrombosis	
Due to Otitis media	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bud Chambers
Address Bud Chambers Dept Date signed 2/26/44 M. D.

G 14461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 14461

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 Popular Grove Ste
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Popular Grove Ste (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas A. Shenbrook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Eliz. M. (Smith)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27 1863

8. AGE: Years 81 Months - Days 27 26 If less than one day hr. min.

9. Birthplace Balto., Md (Town, county, and state)

10. Usual Occupation conductor (Retired)

11. Industry or business

FATHER 12. Name Tom Shenbrook

FATHER 13. Birthplace Unk

MOTHER 14. Maiden Name "

MOTHER 15. Birthplace "

16 (a) Informant Mrs. Eliz M. Shenbrook

(b) Address 726 Popular Grove Ste

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Taylor Ave.

18 (a) Funeral director John F. Connelly

(b) Address 418 Eastern Ave.

19 (a) FEB 26 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1944, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from February 20 1944 to Feb 23 1944, and that I last saw h alive on Feb 22 1944.

Immediate cause of death Myocardial insufficiency.

Duration
several
yrs
25 yrs

Due to Arterio sclerotic type heart disease

Due to Generalized arteriosclerosis

Other Conditions Chronic Rheumatoid arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Mitchell M. D.

Address 290 Edmondson Ave Date signed Feb 25 44

G 14462 GIBSON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 14462 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Furley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Furley Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Alice Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1864

8. AGE: Years	Months	Days	If less than one day
80	-	2	hr. min.

9. Birthplace Ringgold Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name John Blakley

13. Birthplace Ringgold Md

MOTHER — 14. Maiden Name Elizabeth Hancock

15. Birthplace Ringgold, Md.

16 (a) Informant Mrs. Albert Parsons

(b) Address 4211 Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Road

18 (a) Funeral director Howard N. Bligh Jr.

(b) Address 4914 Belair Road Hunting for Baltimore, Md.

19 (a) 2-6-1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1944 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to 2-24 1944 and that I last saw her alive on 2-24 1944.

Immediate cause of death Generalized Carcinomatosis — Duration 18 months

Due to Carcinoma colon — 18 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. Gordy M.D.

Address 5104 Harford Rd Date signed 2-24-44

VS 8

G 74463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 74463
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy McKown.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15-1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas McKown
13. Birthplace Caffney S. C.

MOTHER
14. Maiden Name Berge Biggerstaff.
15. Birthplace Caffney S. C.

16 (a) Informant from History
(b) Address

17 (a) Cremation (b) Date thereof 2-19-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Memorial Hospital
Location 33rd & Calvert Sts, Baltimore

18 (a) Funeral director
(b) Address

19 FEB 21 1944 (b) Hospital Dept. Huntington Pkwy, Md.
(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 44 10:07 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 15 19 44 to Feb. 16 19 44, and that I last saw him alive on Feb. 16 19 44.

Immediate cause of death Asphyxia

Due to Aspiration.

Due to

Other Conditions prematurity.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Morris M. D.
Address Union Mem. Hosp. Date signed 2-16-44

14464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G 14464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2433 S. Paul St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 5
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2433 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Holzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of ~~husband or~~ wife: Florence Holzer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Nov 8th 87
8. AGE: Years 72 | Months 3 | Days 16 | If less than one day: hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Adolph Holzer
13. Birthplace: France

MOTHER
14. Maiden Name: Margaret (Unknown)
15. Birthplace:

16 (a) Informant: Florence Holzer
(b) Address: 2433 St. Paul St

17 (a) Burial, ~~cremation or removal~~: Burial (b) Date thereof: 2-28-27
(c) Cemetery ~~or crematory~~: St. Marys
Location: Hampden

18 (a) Funeral director: William Cook Inc
(b) Address: 2433 St Paul St

19 (a) Date received by Registrar: FEB 28 1927 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1927, at 5 20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiac Disease

Due to

Other Conditions: Arteriosclerotic Gangrene of both Legs and back
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Charles J. Pulaski M.D. (Medical Examiner)
Date signed 2-24-27

CHARLES J. PULASKI

14465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106c

G 14465

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Greene

(c) Hospital or institution: University Hosp. 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town ~~Baltimore~~ Dundalk

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 2489 Janney

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elbert J Tucker

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single.

6 (b) Name of husband or wife: ~~None~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1943

8. AGE: Years	Months	Days	If less than one day
	5	10	hr. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Albert A Tucker

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Hazel M Hamilton

15. Birthplace Dade Md

16 (a) Informant Albert A Tucker

(b) Address 2489 Janney Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-44 (month) (day) (year)

(c) Cemetery or crematory Violers

Location Baltimore Md

18 (a) Funeral director Milton Wolfe

(b) Address 1219 E Fayette St

19 (a) FEB 26 1944 (Date rec'd by registrar) Curtis Tom Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1944, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1944, to 2-25 1944, and that I last saw h i m alive on 2-26 1944.

Immediate cause of death Respiratory Failure — Duration 7 days.

Due to Acute Trachea-Bronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C V Lathington Jr. M. D.

Address Univ. Hosp. Date signed 2-27-44

VS 8

14466

G 14466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 Cold Spring Lane

(c) Hospital or institution:

Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1211 Cox St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Iva Warfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Edgar Warfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9th 1869

8. AGE: Years	Months	Days	If less than one day
74	9	15	hr min

9. Birthplace A. A. Co. Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At home

FATHER

12. Name Roderick Anderson

13. Birthplace A. A. Co. Md.

MOTHER

14. Maiden Name Eliza Redmiles

15. Birthplace Md

16 (a) Informant Agnes Collins

(b) Address 1211 Cox St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 2/26/44

(month) (day) (year)

(c) Cemetery or crematory Edgerton Md

Location Edgerton Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) FEB 26 1944

(Date received by registrar)

(b) Number in register

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1944, at 11 45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19[illegible], to [illegible] 1944, and that I last saw h[illegible] alive on [illegible] 19[illegible].

Immediate cause of death [illegible]

Due to

Due to

Other Conditions [illegible]

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed M D 2/24/44

G 14467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6

G 14467

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6001 Highgate Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 20

(e) Length of stay in Baltimore (yrs., mos., or days) 23 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 6001 Highgate Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Tomms

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-1369

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Laura Tomms

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25th 1881

8. AGE: Years	Months	Days	If less than one day
62	1	29	hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Engraver

11. Industry or business Samuel Kirk

FATHER
12. Name Francis Tomms
13. Birthplace England

MOTHER
14. Maiden Name Caroline (Unknown)
15. Birthplace England

16 (a) Informant Laura H. Arthur
(b) Address 6008 Highgate Drive

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/28/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 1911 St. Paul st.

FEB 26 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1944, at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1944, to Feb 24 1944, and that I last saw him alive on Feb 24 1944.

Immediate cause of death Coronary thrombosis — Duration 7 days.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melton E. Lowman M. D.
Address 5803 Park Heights Ave Date signed 2-25-44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

RHNS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 14468 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Eagle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Eagle St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Diane E. Braun

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2/43

8. AGE: Years	Months	Days	If less than one day
	4	31	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles W. Braun
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Elsie Rosenstein
15. Birthplace Balto. Md

16 (a) Informant Mrs Chas. Braun
(b) Address 2226 Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Henry H. Meyer
(b) Address 4016 Edmondson Ave

(c) Date rec'd by registrar FEB 26 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1944, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1944, to Feb 23 1944 and that I last saw her alive on 2/23/1944.

Immediate cause of death

Due to Lobar Pneumonia — Duration 2d

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Parson
Address Hall Mar Date signed 2/24 D.

14468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G 14468 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 W. Cullen
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 W. Cullen St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bernard Webb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	Married

6 (b) Name of husband or wife Mildred
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 11-18-89

8. AGE: Years	Months	Days	If less than one day
55-56	3	6	hr. min.

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation P. S. Teacher
11. Industry or business

FATHER
12. Name James E. G. Hart
13. Birthplace Md

MOTHER
14. Maiden Name Mary Roberts
15. Birthplace Md

16 (a) Informant Walter Hart
(b) Address 2409 Madison ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 27-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director James A. Stays
(b) Address 1142 Wadsworth Ave

19 (a) FEB 26 1944 (Date rec'd by registrar) Mountington Willis M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1944 at 5:31 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1944 to Feb 24 1944 and that I last saw h~~e~~ alive on Feb 23 1944.

Immediate cause of death: Mitral Insufficiency — Duration
Due to
Due to General Edema
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M. D.
Address 1612 E Monument Date signed 2/7/44

G 14470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G 14470 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1143 RIDGELY ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 Ridgely St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE F LEWIS

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-06-8176

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife SARAH LEWIS
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) DEC. 21 - 1884

8. AGE: Years	Months	Days	If less than one day
59	2	4	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation GLASS WORKER
11. Industry or business SWINDALL CO

FATHER
12. Name WILLIAM T. LEWIS
13. Birthplace BALTO, MD.

MOTHER
14. Maiden Name ELIZABETH C PURSINETTE
15. Birthplace BALTO. MD.

16 (a) Informant MRS SARAH LEWIS
(b) Address 1143 RIDGELY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 29-44 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN CEM
Location GLENBURNIE A.A. Co

18 (a) Funeral director Bernard C Hahn
(b) Address 121 E WEST ST

FEB 26 1944 (b) Huntington Williamsport, MD
(Date received by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 25 1944 at 5:28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5 1944 to 2/24 1944, and that I last saw h[im] alive on 2/24 1944.

Immediate cause of death: Acute cardiac failure — Duration
Due to Coronal arteriosclerosis
Due to Ch Nephritis
Other Conditions Generalized Edema

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. H. Hornstein M. D.
Address 733 Argyle St Date signed 2/26/44

G 14471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G 14471

YA-86423

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 601 S. Streeper St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Bures

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1862

8. AGE: Years	Months	Days	If less than one day
81	7	6	hr min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name ~~[illegible]~~ Wm. A. Bures

13. Birthplace Md.

MOTHER

14. Maiden Name Katherine Jammert

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Feb. 27-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cem.

Location E. Dorsey St.

18 (a) Funeral director John H. Miller

(b) Address 2334 Jefferson St.

FEB 26 1944

(Date rec'd by registrar) Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1944, at 2100 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1944, to 2-24 1944, and that I last saw him alive on 2-24 1944.

Immediate cause of death

Pyelonephritis

Due to Urinary Retention

Due to Benign Prostatic Hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation:

of autopsy:

Duration
yr.
9 days
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Donald B. Dell M. D.

Address Balto City Hosp Date signed 2-24-44

14472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14472
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 885 W. Fairmount Ave E.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 885 W. Fairmount Ave E. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Henson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. unknown

6 (b) Name of husband or wife unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown —

8. AGE: Years 66 | Months — | Days — | If less than one day hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Domestic
11. Industry or business

MOTHER / FATHER
12. Name unknown
13. Birthplace unknown
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Earl Young
(b) Address 1503 Fenton St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 2 26 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calary County
Location Balto. Md.

18 (a) Funeral director Walter B. Young
(b) Address 139 W. Hamburg St.

19 (a) FEB 26 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1944, at 8 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/16 1944 to 2/23 1944.
and that I last saw her alive on 2/22 1944

Immediate cause of death Coronary Occlusion
Due to Chronic Endocarditis
Due to Hypertension

Duration

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Trumbauer
Address [illegible] Date signed 2/24/44 M. D.

C 14473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 14473 / 1312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2412 Annapolis Rd.
(c) Hospital or institution:

2572

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Annapolis Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BRADLEY HARRISON CAVEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carrie M. Cavey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1889

8. AGE: Years	Months	Days	If less than one day
54	7	3	hr. min.

9. Birthplace Howard Co., Md. (Town, county, and state)
10. Usual Occupation Operator of Oil Burner
11. Industry or business Davidson Chem. Co.

FATHER
12. Name Ezekiel Cavey
13. Birthplace ?

MOTHER
14. Maiden Name Rebecca Tacey
15. Birthplace ?

16 (a) Informant Mrs. Carrie M. Cavey
(b) Address 2412 Annapolis, Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 26 1944 Huntington Williams, M.D. Registrar
(Date received)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1944, at 1:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 19 44 to Feb 27 19 44, and that I last saw h[er] alive on Feb 22 19 44.

Immediate cause of death
Pulmonary Tuberculosis
Due to Bronch. Pneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 3 yrs 3 weeks

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Lubrano M. D.
Address 5217 Reisterstown Rd Date signed 2/25/44

G 14474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14474 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1608 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1608 Light St. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AMANDA VIRGINIA HAWKINS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John Frederick Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/26/1859

8. AGE: Years	Months	Days	If less than one day
84	11	28	hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Samuel Henry Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Amanda Essex
15. Birthplace Md.

16 (a) Informant Dr. J. Frederick Hawkins
(b) Address 8 E. 39th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1944 at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944 to Feb 24 1944 and that I last saw her alive on Feb. 24 1944

Immediate cause of death Cardiac thrombosis

Due to Senile myocardial dgn.

Due to Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Duration 2 hrs 5 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frederick Hawkins M. D.
Address 8 E. 39th St. Date signed 2/24/44

14475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C 14475 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3724 Tudar Arms Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3724 Tudor Arms Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: HOWARD S. SHELDS

3 (b) If veteran, name war: --

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lydia

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 29, 1884

8. AGE: Years 59 | Months 10 | Days 25 | If less than one day: hr. min

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Insurance Real.

11. Industry or business: Self

FATHER
12. Name: Henry Shields
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Louisa A.
15. Birthplace: --

16 (a) Informant: Mrs. Lydia Shelds
(b) Address: 3724 Tudor Arms Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md

(a) Date received FEB 26 1944 (b) Signature for Williams M.P. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1944 to Feb 24 1944, and that I last saw h/ alive on Feb 24 1944.

Immediate cause of death: Coronary thrombosis — Duration: 24 hrs.

Due to: Arteriosclerosis — 4 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Arthur J Danes M. D.

Address 800 N Stricker Date signed 2-25-44

G 14476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163H

G 14476 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-1A
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 N. Spring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeanette E. Cooper

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	215-03-3092

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Clarence Cooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1918

8. AGE: Years	Months	Days	If less than one day
26	1	6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Bakers Helper
11. Industry or business Bond Bakery

FATHER
12. Name Wilmer Tracey
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Henrietta Hiltz
15. Birthplace Baltimore County

16 (a) Informant Mr. Clarence Cooper (Husband)
(b) Address 1500 N. Spring Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Morlands Park
Location Taylor Ave. Balto; Co.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 Filed FEB 26 1944 Huntington Williams, M.D. (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25- 19 44, at 3:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-25- at probably P.M.? M.
(b) Where did injury occur? 1500 N. Spring St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Open gas - cock on wall

23. Signature Howard J. Luckett M.D. Medical Examiner.
Date signed 2-25-44

C 14477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

C 14477 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Lindsay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1872

8. AGE: Years	Months	Days	If less than one day
72	1	11	hr. min.

9. Birthplace Buffalo, N. Y. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name George I. Lindsay
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary
15. Birthplace Montreal, Canada

16 (a) Informant Paul K. Lindsay
(b) Address R.F.D. No. 2 A. Cooper Jr. Orford, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

FEB 26 1944 (Date received by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1944 to Feb 23 1944 and that I last saw him alive on Feb 22 1944

Immediate cause of death Cystitis
Due to Bronchial Asthma
Due to
Other Conditions None
(Include pregnancy within 3 months of death)

Duration 3 Days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Peterson M. D.
Address 817 W. Hamilton Ave. Date signed Feb 26 '44

VS 150

G 14478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 14478
Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3739 Elm Avenue
(c) Hospital or institution:

12-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3739 Elm Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME E. Howard Shearer

3 (b) If veteran, name war F
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife C. Irene McFadden
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 25-1885

8. AGE: Years 58 | Months 5 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual Occupation Barber
11. Industry or Business

FATHER
12. Name Jacob F. Shearer
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Lyam
15. Birthplace Maryland

16 (a) Informant Mrs. C. Irene Shearer
(b) Address 3739 Elm Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28-1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) FEB 26 1944 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27- 1944 at 4:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Feb. 1944, and that I last saw him alive on Feb 27 1944.

Immediate cause of death: Coronary Thrombosis — Duration 5 min.
Due to arteriosclerosis. — 6 mos.
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Gilbert K. Worland Jr. M. D.
Address 2706 St Paul St Date signed 2/29/44

G 14479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 14479

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 Union Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Union Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Edward Evans

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-07-4916

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel M. Evans

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 10-1894

8. AGE: Years 49 | Months 5 | Days 15 | If less than one day: hr. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business Jno. S. Foster & Sons Co

FATHER: 12. Name John H. Evans
13. Birthplace Maryland

MOTHER: 14. Maiden Name Agnes Schaffer
15. Birthplace Maryland

16 (a) Informant Mrs. Ethel M. Evans
(b) Address 1314 Union Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28. 1944 (month) (day) (year)

(c) Cemetery or crematory St Marys (Hamden)
Location Baltimore Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3021 Fipps Road

FEB 26 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25- 1944 at 12 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 42. to Feb 25 1944.
and that I last saw h[illegible] alive on Feb 25 19 44.

Immediate cause of death: Coronary Thrombosis — Duration: 1 wk.

Due to Arteriosclerosis (CVD) — 7

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3711 Pacific Pl Date signed 2-25-44

SHIMANEK

14480

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14480
Registered No. 160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 W. Lombard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Infant
6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb-24-1944

8. AGE: Years — Months — Days 5 If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Ira Wood
13. Birthplace Balto., Md

MOTHER
14. Maiden Name Mildred M. Batton
15. Birthplace Balto., Md

16 (a) Informant Ira Wood (Father)
(b) Address 6 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto., Md.

18 (a) Funeral director G. Howard Emery
(b) Address 1400 St. Charles St

19 (a) ... (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

FEB 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1944, at 1:00 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hematoma

Due to birth injury

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed Feb 26 1944

G 14481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1576

G 14481 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 843 Herndon Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 843 Herndon Court (Brooklyn) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Louis Vissage

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife: None
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1943

8. AGE: Years: 0 | Months: 3 | Days: 22 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: None

FATHER
12. Name: James D. Vissage
13. Birthplace: S. Car.

MOTHER
14. Maiden Name: Eleanore Kine
15. Birthplace: S. Car.

16 (a) Informant: James D. Vissage
(b) Address: 843 Herndon Court

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: Feb. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory: Mountain Rest
Location: Walhalla, S. Car.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St Paul St Baltimore, Md

19 (a) (Date received by Registrar) (b) Registrar

FEB 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 26 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1943, to Feb. 26 1944, and that I last saw h[illegible] alive on Feb 26 1944.

Immediate cause of death: Bronchial Pneumonia. — Duration: 3 weeks
Due to
Due to
Other Conditions: Congenital Spina Bifida Anemia Malnutrition contributory
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Paul Lubin M. D.
Address 320 Autaugaw Date signed 2/26/44

G 14482

JL - 86602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G 14482 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13h-15m

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4434 Newport Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Loeffler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Ralph William Loeffler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1888

8. AGE: Years	Months	Days	If less than one day
55	8	14	hr min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: Paul Weidermann

13. Birthplace: Germany

MOTHER

14. Maiden Name: Bertha Stein

15. Birthplace: Germany

16 (a) Informant: B. C. H. Records

(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26/44 (month) (day) (year)

(c) Cemetery or crematory: Moreland Park

Location: Taylor Ave

18 (a) Funeral director: Edward P. Donovan

Address: 17 Chestnut Ave.

FEB 20 1944

19 (a) Huntington Williams Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2·24 1944, at 12 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2·23 1944 to 2·24 1944, and that I last saw her alive on 2·24 1944.

Immediate cause of death

Carcinoma of Rectum with metastases.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

Duration
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald B. Kelly

Address Balt City Hosp Date signed 2-29-44

VS 150

G 14483

SIMMS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14483 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel A. J. Simms

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Simms

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1860

8. AGE: Years 83 | Months 5 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and State)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Henry Simms
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza ?
15. Birthplace

16 (a) Informant Mrs Mary Simms
(b) Address 712 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs Francis A. Hemsley
(b) Address 578 W. Biddle St

19 (a) FEB 26 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1944 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1944 to 2-25 1944, and that I last saw h[illegible] alive on 2-25-1944.

Immediate cause of death: Cardiovascular disease — Duration: 9

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. I. Camper M. D.
Address 639 N. Carey St. Date signed 2-26-44

G 14484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 14484 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 2 8 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4603 Post Rd
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Martin J. Lepka, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian (nee Diller)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1903

8. AGE: Years	Months	Days	If less than one day
40	7	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Gas & Elec. Co.

FATHER
12. Name Martin Lepka
13. Birthplace Unknown

MOTHER
14. Maiden Name Vacek
15. Birthplace Unknown

16 (a) Informant Wife
(b) Address 4603 Post Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or ~~Funeral~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

FEB 26 1944 Huntington Nathanuel, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 24 - 1944, at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-25-44

G 14485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

G 14485 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hyman Park and 31st St.,
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Maryland
(c) City or town Altoona (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 2nd Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE CHARLES CHRAMEK

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 171-07-9493

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena Catrell
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9/12/01

8. AGE: Years 42 | Months 5 | Days 14 | If less than one day: hr. ____ min. ____

9. Birthplace Budapest, Hungary (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business

FATHER
12. Name George Chramek
13. Birthplace Hungary

MOTHER
14. Maiden Name LenaCatrell
15. Birthplace Mary Vass Hungary

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Altoona, Pa.
Location

18 (a) Funeral director William J.Tiekner &Sons
(b) Address North & Pa. Aves.

FEB 26 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1944 at 3:25a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28, 1943 to Feb. 26, 1944, and that I last saw him alive on Feb. 26, 1944.

Immediate cause of death: Generalized metastases — Duration: Unk.

Due to Carcinoma of rt. kidney, post operative — Duration: 18 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature [signature]
M. D.
Address US Marine Hospital, Baltimore, Md. Date signed 2/26/44

14486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14486
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wk
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 W. Conway St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James P. Gwin

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-6915A

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years: 67 | Months | Days | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mary Johnson
(b) Address 1165 Warner Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. Md.

18 (a) Funeral director Isaiah L. Brown Son
(b) Address 168 W Montgomery Street

FEB 26 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1944, at 9:24 P. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Williamson M.D.
Medical Examiner.
Date signed 2-24-44

VS 151

G 14487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G 14487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1040 W Baraloyn
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 W Baraloyn (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ada Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	col	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/29/14

8. AGE: Years	Months	Days	If less than one day
29	8	23	hr. min.

9. Birthplace Aug. Co. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Richard Edwards
13. Birthplace Md

MOTHER
14. Maiden Name Mamie Wallace
15. Birthplace Md

16 (a) Informant Richard Edwards
(b) Address 1040 W Baraloyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

FEB 26 1944 (Date rec'd by registrar)

(c) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-1944 at 7 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-1944 to 2-22-1944, and that I last saw h alive on 2-21-1944.

Immediate cause of death Sclar Pneumonia Acute Endocarditis — Duration 4 days 1 hr.

Due to

Due to

Other Conditions Accidents

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. T. Jackson M. D.

Address 6004 Edmondson Ave Date signed 2/26/44

VS 150

JL- 86125 G 14488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 14488

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
4940 Eastern. Ave.

(b) Street address

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2 14

(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1613 McCulloh St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1908

8. AGE: Years	Months	Days	If less than one day
35	6	20	hr min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Grover
13. Birthplace S. C.

MOTHER
14. Maiden Name Amanda McNeil
15. Birthplace S. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-26-44 (month) (day) (year)

(c) Cemetery or crematory Dillon. S. C.

Location Dillon (Marion Co) S. C.

18 (a) Funeral director William A. Jackson

(b) Address 416 Penna. Ave.

19 (a) Date received by registrar FEB 27 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25/44 19 ... at 6 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1944, to 2/26 1944, and that I last saw him alive on 2/24 19 44.

Immediate cause of death Miliary Tuberculosis — Duration

Due to Pulmonary T.B.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Miliary T.B.

of autopsy: T.B. peritonitis.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. Nelson M.D.

Address Balto. City Hosp. Date signed 2/25/44 M.D.

G 14489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14489 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave
(c) Hospital or institution Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 W. Madison St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? --- years

3 (a) FULL NAME Mr. Samuel C. Mann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mayme ---
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1871

8. AGE: Years	Months	Days	If less than one day
72	6	20	-- hr. --- min.

9. Birthplace Chestertown, Md. (Town, county, and state)
10. Usual Occupation Night Manager
11. Industry or business Hotel Business

FATHER
12. Name Samuel Mann
13. Birthplace Kent County, Md.

MOTHER
14. Maiden Name Mary Louisa Wilmer
15. Birthplace Kent County, Md.

16 (a) Informant Mrs. Elise Mann Hoyle
(b) Address Chestertown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 605 N. Calvert Street

FEB 27 1944

19 (a) Huntingtown Hilliard, Md.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1944, at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1944, to 2-25 1944, and that I last saw her alive on 2-25 1944.

Immediate cause of death: Respiratory paralysis — Duration

Due to Hemorrhage into pons and med.

Due to Hypertension & Uremia

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D. Young Jr., M. D.
Address Med. Gen. Hospital Date signed 2-25-44

G 14490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G 14490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 61 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME August C. Volk

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced.** Widowed

6 (b) Name of husband or wife Mary C. Ellinghaus
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ------- 1881

8. AGE: Years 63 | Months y.? | Days | If less than one day ... hr. ... min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation None

11. Industry or business ------

FATHER
12. Name Killiam Volk
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Gehring
15. Birthplace Germany

16 (a) Informant Raymond Volk
(b) Address 2619 N. Hilton Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 2/28/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) FEB 27 1944 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1944, at 7:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature H. W. Kleinschmidt M.D.
Medical Examiner.
Date signed 2-24-44

VS 151

G 14491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 E. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia W. Jenkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Louis W. Jenkins

6 (c) If alive, ~~give age~~ No. years

7. Birth date of deceased (mo., day, yr.) June 1 - 1870

8. AGE: Years 73 74 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name P. Pittroff
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Eugene F. Jenkins
(b) Address 2827 E. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28 44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Most Holy Redeemer
Location Belair Rd, Balto. Md

18 (a) Funeral director Milton Schilling
(b) Address 3914 E. Hanover St

FEB 27 1944 (b) Registrar
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Febr 24th 1944 at 9 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1943, to Febr 1944, and that I last saw h~~e~~r alive on Febr 22 1944

Immediate cause of death	Duration
Pulmonary Edema	2 days
Due to Cardio Renal Disease	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. F. Jenkins M. D.
Address 100 N Milton Date signed 2/28/44

Huntington Williams, M.D.

449591 G 14492

✓ G 14492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1360

Registered No. G 14492

PLEASE WRITE PLAINLY, WITH UNPADDING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. Arundel
(c) City or town ANNAPOLIS (If outside city or town limits, write RURAL and give town)
(d) Street No. 72 1/2 LARKIN St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Jacob Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	BLACK	Div

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-9-80

8. AGE: Years	Months	Days	If less than one day
63	4	13	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Oyster Shucker
11. Industry or business

FATHER
12. Name John Green
13. Birthplace Md

MOTHER
14. Maiden Name Jennie Cook
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Stevensville, Md.

18 (a) Funeral director Wm. George H. Hallock
(b) Address 1631 Druid Hill Ave

FEB 27 1944 (Date rec'd by registrar) (b) Huntington Hollinsworth, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1944 at 8.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1944, to Feb 22 1944, and that I last saw him alive on Feb 22 1944.

Immediate cause of death	Duration
Uraemia	
Due to Pyohydronephrosis - left	
Due to Chronic urethral stricture	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-21-44
Major findings of operations: Same
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell B. Robb M. D.
Address Johns Hopkins Hosp. Date signed 2-25-44

G 14493

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14493 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette St
(c) Hospital or institution: Bon Secours.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. None (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Calhoun McCurdy, JR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day hr.	min.
Abt. 56				

9. Birthplace Wheeling, W. Va. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name John C. McCurdy, Sr.
13. Birthplace Wheeling, W. Va.

MOTHER
14. Maiden Name Anna George
15. Birthplace Wellsburgh, W. Va.

16 (a) Informant Dr. John McCurdy
(b) Address Wheeling, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-44 (month) (day) (year)
(c) Cemetery or crematory Stone Church Cem.
Location Wheeling W Va

18 (a) Funeral director A. Leo Oder
(b) Address 1644 York Rd

FEB 27 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1944, at 6 35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1944, to 2/26 1944, and that I last saw him alive on 2/26 1944.

Immediate cause of death Congestive Heart Failure — Duration 24 hrs
Due to Lobar Pneumonia. (Left - Lung) — 7 days
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond Long M. D.
Address Bon Secours Hosp Date signed 2/26/44

(OVER)

G 14494

JL - 81545

G 14494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 138

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 423 S. Parrish St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME W. George Metcalf

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1884

8. AGE: Years	Months	Days	If less than one day
60	0	18	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name George Metcalf

13. Birthplace Md.

MOTHER

14. Maiden Name Margaret Cook

15. Birthplace Md.

16 (a) Informant B. C. H.

(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)

(c) Cemetery or crematory LAUREL PARK

Location BALTIMORE, MD

18 (a) Funeral director F. B. WIPPERTSON

(b) Address 1850 W. BALTIMORE ST

19 (a) FEB 27 1944 (date received by registrar) (b) Huntington Hollingsworth (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1944, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1943, to 2/24 1944, and that I last saw h[illegible] alive on 2/24 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration 1 Year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Matt M. D.

Address B. C. H. Date signed 2/24/44

(over)

G 14495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 14495

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway Mansions
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 W Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wise
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-9-83

8. AGE: Years	Months	Days	If less than one day
60	10	17	hr min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Life Insurance
11. Industry or business

FATHER
12. Name George Wise
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Wegfenth
15. Birthplace Md

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof 2/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON-PARK
Location Baltimore-Md
18 (a) Funeral director F. A. WIPPERT-SON
(b) Address 700 Eutaw Place
19 (a) (b) Huntington Woods
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1944 to Feb 26 1944; and that I last saw him alive on Feb 26 1944

Immediate cause of death	Duration
Cerebral accident c left hemiplegia	
Due to ? thrombosis of artery	
Due to arteriosclerosis	
Other Conditions bilateral empyema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Cunningham JHH
Address Date signed 2-26

G 14496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14496 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 South Road
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 South Road (If rural give location)
(e) Citizen of foreign country? -No- (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Lee Bennett Griffith

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: J. Edwin Griffith.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Abt. June 14 1863

8. AGE: Years	Months	Days	If less than one day
Abt. 80	8	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Geo. W. Bennett
13. Birthplace St Mary's Co. Md

MOTHER
14. Maiden Name Anne Elizabeth
15. Birthplace Baltimore Md

16 (a) Informant Mr. J. Edwin Griffith Jr. (SON)
(b) Address 1703 South Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108 W North ave

19 (a) FEB 27 1944 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1944 at 11 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Feb 25 1944; and that I last saw her alive on Feb 24 1944.

Immediate cause of death: Bronchial Pneumonia — Duration 3 days
Due to Paralysis of Left Side — 2 1/2 yrs
Due to arteriosclerosis — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Kuppel M. D.
Address Wedtworth Office Date signed 2-25-44

G 14497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 14497 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 Hollins St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary D. Railey

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	late Widow

6 (b) Name of husband or wife: Phillip C. Railey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17-1863

8. AGE: Years	Months	Days	If less than one day
81	1	8	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Tarleton
13. Birthplace Md

MOTHER
14. Maiden Name Isabel Spalding
15. Birthplace Pa

16 (a) Informant Mrs. Charles Railey
(b) Address 1717 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem
Location Balto. Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 151 N Gilmor St.

FEB 27 1944 (Date rec'd by registrar) (b) Huntington Hollingsworth M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1944 at 1.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 Feb. 25 1944 and that I last saw h- alive on 2/25 1944.

Immediate cause of death	Duration
Carcinoma of sigmoid	1 yrs
Due to	
Due to	
Other Conditions Carcinoma of liver (Include pregnancy within 3 months of death)	6 mos

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2020 Wilkens Date signed Feb 27 1944

G 14498

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14498
Registered No. 1108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 0 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Hancock

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: non

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Unknown
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) about 1870
8. AGE: Years 74 | Months | Days | If less than one day hr. min.
9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hancock
13. Birthplace Unknown

MOTHER
14. Maiden Name --
15. Birthplace --

16 (a) Informant Mrs. J. Ahern
(b) Address 324 Jackson Blvd.
17 (a) Burial, cremation or removal
(b) Date thereof (month) (year) 1944
(c) Cemetery or crematory
Location
18 (a) Funeral director W. M. Cook Inc.
(b) Address 1217 St Paul St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1944, at 1 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobar right
Due to
Other Conditions Arteriosclerosis + General
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. W. Ahern M.D.
Medical Examiner.
Date signed 2-24-44

G 14499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14499 Registered No. 518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Hamilton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L Forsythe

3 (b) If veteran, name war No

3 (c) Social Security Account No. 221-07-5219

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27. 1891

8. AGE: Years 72 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business D. B. Taylor

FATHER
12. Name John A Forsythe
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Eliza Ehrson
15. Birthplace Baltimore Md

16 (a) Informant Nellie Forsythe
(b) Address 421 Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson & Cook Inc
(b) Address 1217 E Fayette St

19 (a) (Date received by local registrar) (b) Huntington Williams, M D Registrar

FEB 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to Feb 26 1944 and that I last saw h(IM) alive on Feb 26 1944.

Immediate cause of death	Duration
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

G 14500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 14500 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1340 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond E. KENNEDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Myrtle Kennedy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 1886

8. AGE: Years	Months	Days	If less than one day
57	8	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Detective Service
11. Industry or business Self

FATHER
12. Name Michael R. Kennedy
13. Birthplace Md.

MOTHER
14. Maiden Name Veronica Welch
15. Birthplace Phila. Pa.

16 (a) Informant Mrs John Cunel
(b) Address 1340 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 (a) (Date rec'd by registrar) (b) Lington Williams M.D. Registrar

FB 24 VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26, 1944, at 4.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1944 to 2/26 1944 and that I last saw him alive on 2/26 1944.

Immediate cause of death: Cerebral hemorrhage.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M.D.
Address 1213 Light St Date signed 2-26-44

G 14501 5 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G 14501

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 296 Dallas Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 296 Dallas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel B. ~~Gallicher~~ Galliher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Mary E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 1866

8. AGE: Years	Months	Days	If less than one day
77	4	16	hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name John Galliher

13. Birthplace Unknown

MOTHER 14. Maiden Name Elizabeth Barker

15. Birthplace Va

16 (a) Informant Mrs Virginia Shields

(b) Address 296 Dallas Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)

(c) Cemetery or crematory Dayes Cemetery

Location Doc Gulley W Va

18 (a) Funeral director William M Mareck

(b) Address 715 Lizet St

(c) Date received FEB 27 1944 (b) Huntington Williamson W Va

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1944, at 9 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1944, to Feb 25 1944, and that I last saw him alive on Feb 24, 1944.

Immediate cause of death: Carcinoma of the bowel with general metastases

Duration: 2

Due to —

Due to —

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.

Address 1926 Hanover St. Date signed 2/29/44

G 14502

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

G 14502

1310 Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1739 Decatur St.

Hospital, institution, or street address where death occurred: N

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1739 Decatur St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James L. Martin

3.(b) Social Security Number 212-10-7824

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	married

6.(b) Name of husband or wife Martha Martin

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) May 12 1911

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
32	9	12		

9. Birthplace Va. (Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business Chemical Co.

MOTHER FATHER

12. Name Luther Martin

13. Birthplace Va.

14. Maiden name Betty Collier

15. Birthplace Va

16. Informant Mrs. Martha Martin

Address 1439 Decatur St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/28/44 (month) (day) (year)

Cemetery or crematory Cedar Hill Cem.

Location Annapolis Rd.

18. Funeral director Chas. F. Dill.

Address 1301 E. Fort Ave.

FEB 27 1944 19 Huntington Williams, M.D. Registrar

(Date rec'd by Registrar)

FEB 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 19 44, at 6 55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 21 19 44, to Feb. 24 19 44, and that I last saw h alive on Feb 24 19 44

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 Day
Bronchial Pneumonia	2 Day
Due to Uremic Coma	3 d
Due to Nephritis	3 d
Other conditions Chronic Glomerulo Nep.	3 Da

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E E U Stevens M. D. or other

Address 2818 Hartford Rd Date signed 2-26 44

G 14503

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 94a

Reg. Dist. No.

G 14503

1. PLACE OF DEATH:

County

City or town: Baltimore (If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death? 4803 Old York Rd.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 4803 Old York Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John. Wolf.

3.(b) Social Security Number 088-05-6133

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Gertrude Wolf.

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): November 30.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
58.	2	24		

9. Birthplace (Town, county, and state)

10. Usual occupation: Retired Stevedore

11. Industry or business

FATHER — 12. Name: John. Wolf.

13. Birthplace: Germany.

MOTHER — 14. Maiden name

15. Birthplace

16. Informant: Mrs. Margaret Espich

Address: 4803 Old York Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/28/44 (month) (day) (year)

Cemetery or crematory: Maryland Memorial Park.

Location: 6806 Harford Rd.

18. Funeral director: Chas. F. Dill.

Address: 1201 E. Fort Ave.

19. 2-27-1944 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27 1944, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1944 to Feb 27 1944

and that I last saw h. alive on Feb 23 1944

Immediate cause of death	DURATION
Coronary occlusion	4 days
Due to	
Due to	
Other conditions: Bronchial asthma (Include pregnancy within 3 months of death)	2 years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Miller M.D. M. D. or other

Address 1225 N. Charles St. Date signed 2/28/44

JL -59083 G 14504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14504 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.,

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 -5 - 12

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1207 Whetcoat St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Burley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Nora (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 187?

8. AGE: Years	Months	Days	If less than one day
69 ?	?	?	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Odd jobs

11. Industry or business

FATHER
12. Name William
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Snowden
15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 2 28 44
(month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director J. J. Zahnt Sons

(b) Address 1318 Light St

FEB 27 1944 (b) Huntington Williamsport Md
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1944, at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943, to 2/22 1944, and that I last saw him alive on 2/22 1944.

Immediate cause of death Bronchopneumonia — Duration ?

Due to

Due to

Other Conditions H.S.U.D. ; gen. arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. L. Sergmon M.D.

Address BCH Date signed 2/25

JO #64951 G 14505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 W. Mosher St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Burke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1902

8. AGE: Years	Months	Days	If less than one day
41	6	3	hr min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name William (d)
13. Birthplace Maryland
14. Maiden Name Lillian West (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 2 28 44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Furnace Hill Rd

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1318 Light St

19 (a) FEB 27 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1944, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 19 44, to 2/22 1944, and that I last saw him alive on 2/22 19 44.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl R. Kinney M. D.
Address Balt. City Hosp. Date signed 2/24/44

G 14506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 14506 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Md. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Dudley Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs. Ottilie Pfeifer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	7	2		

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Michael Stiemly
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Walters
15. Birthplace Baltimore

16 (a) Informant Mr. Charles W. Pfeifer Jr.
(b) Address 3409 Dudley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North ave

18 (a) Funeral director E. Walter May
(b) Address 619 N. Bouldin St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature)

FEB 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1944, to Feb. 25 1944, and that I last saw h[illegible] alive on Feb 25 1944.

Immediate cause of death — Duration

Subarachnoid hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Herman Williams M. D.
Address Md. Gen. Hosp Date signed Feb. 25, 1944

G 14507

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 14507 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3033 Presstman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3033 Presstman
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh D. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-8439

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of ~~husband~~ or wife Elizabeth M. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1875

8. AGE: Years	Months	Days	If less than one day
68	2	9	hr. min.

9. Birthplace Edinburg, Va.
(Town, county, and state)
10. Usual Occupation Press Operator
11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Robert J. Miller
13. Birthplace Edinburg, Va.

MOTHER
14. Maiden Name Elizabeth L. Hockman
15. Birthplace Edinburg, Va.

16 (a) Informant Mrs. Joseph Glatt
(b) Address 3033 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Howard Co. Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) Date received (Registrar) (b) Huntingtown Williams MD

B 27 1944

VS 150

MEDICAL CERTIFICATION 6.00

20. DATE OF DEATH Feb. 25, 1944 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1944 to 2-25 1944, and that I last saw h~~im~~ alive on 2-25 1944.

Immediate cause of death Cardio-Vascular Renal — Duration 11 days
Due to Acute Nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard H. Warner M. D.
Address 704 Garrison Blvd Date signed 2-26-44

G 14508

JL- 83765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G 14508 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 4940 Eastern Ave.

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hr-35 m.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 309 S. Sharpe St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John W. Brewer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1902

8. AGE: Years	Months	Days	If less than one day
42	1	4	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER — 12. Name William C.

13. Birthplace Md.

MOTHER — 14. Maiden Name Kate

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial or removal) (b) Date thereof 2/27/44 (month) (day) (year)

(c) Cemetery Washington D.C

Location

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) Huntington Williams, M.D. Registrar

(Date rec'd by registrar) FEB 29 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/44 19 at 3:28 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1943 to 2/27 1944 and that I last saw h[e] alive on 2/26 1944

Immediate cause of death Pulmonary T.B.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Favorable Pul. T.B

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Acton, M. D.

Address Balto. City Hosp. Date signed 2/27/44 M. D.

G 14509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G 14509 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 E. Monument St. (Or other location)
(e) Citizen of foreign country? Mt. Vernon Place (Yes or No) If yes, name country

3 (a) FULL NAME Robert Schotta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Grace Schotta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18th 1892

8. AGE: Years	Months	Days	If less than one day
51	9	8	hr. min.

9. Birthplace Ellicott City Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Ellsworth Schotta
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Ryan
15. Birthplace Md.

16 (a) Informant Mrs Grace Schotta
(b) Address 214 Noble St. West Haven, Conn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1317 St. Paul St.

19 (a) FEB 28 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1944, at 12:25 A M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hemorrhage of Brain

Due to Fracture of skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 17, 1944 11/2 3:00 A M.
(b) Where did injury occur? 100 Block W. Monument St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Beaten

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed February 26, 1944

G 14510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G 14510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md Geal Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Wilton Ave. Towson
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ethel E. Crowley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John J. Crowley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11 1889

8. AGE: Years	Months	Days	If less than one day
54	67	16	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Charles Clay Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret McKee
15. Birthplace Md.

16 (a) Informant John J. Crowley
(b) Address 612 Wilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Maria
Location Towson Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

FEB 28 1944 (Date filed by registrar) (b) Hunter Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1944, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944 to 2/27 1944, and that I last saw h BT alive on 2/22 1944.

Immediate cause of death Lobar pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy Bilateral lobar pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Earl Myers M.D.
Address 612 Wilton Ave. Date signed 2/27/44 M.D.

14511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G 14511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4526 Westfield ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Irene Kindall

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 12 1944

8. AGE: Years	Months	Days	If less than one day
2 wks. 0	0	14	3 hr. 30 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Joseph David Kindall
13. Birthplace Baxto Md.

MOTHER
14. Maiden Name Hester Stein
15. Birthplace Balto. Md.

16 (a) Informant Joseph D Kindall
(b) Address 4526 Westfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/44 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cox inc
Address 217 E. Pratt st

FEB 28 1944
19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944, at 7:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1944 to 2-26 1944
and that I last saw h alive on 2-24 1944

Immediate cause of death Diarrhea — Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 2-27-44

VS 8

G 14512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G 14512 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2850 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME HELEN BARBARA WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 4th 1937

8. AGE: Years	Months	Days	If less than one day: hr	min
6	6	23		

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Howard Wilson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Helen Mayers
15. Birthplace Balto. Md.

16 (a) Informant Helen Wilson
(b) Address 2850 W. North Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/1/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) FEB 28 1944 (Date rec'd by registrar) (b) Huntington Indiana Registrar

VR 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1944 at 8 25 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-26-44 at 10:30 P. M.
(b) Where did injury occur? North Ave & Patterson Park
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury pedestrian struck by auto car

23. Signature W. L. Wollenweber M.D. (Medical Examiner)
Date signed 2-28-44

G 14513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

Registered No. G 14513

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline st

(c) Hospital or institution St Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 31.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 505 S Ann Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank De Martini

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-01-9409

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ wife Evelyn

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) May 1st 1914

8. AGE: Years	Months	Days	If less than one day
29	9	25	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Cannon shoe Co

FATHER
12. Name Frank De martini
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Veronica Kedzierska
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Veronica De martini

(b) Address 1913 aliceanna st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-44 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber

(b) Address 2034 Aisquith st.

19 (a) FEB 28 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944, at 4 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1944 to Feb 26 1944, and that I last saw him alive on Feb 26 1944.

	Duration
Immediate cause of death Pulmonary edema with generalized anasarca	
Due to Amyloid nephrosis of Kidneys.	
Due to Caronic active pulmonary Tbc.	
Other Conditions Anemia (secondary) Beginning uremia (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas Brennan M. D.

Address St Joseph's Hospital Date signed 2-26-44

VS 150

G 14514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 14514 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 Marshall st.
(c) Hospital or institution: Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Marshall st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Anna M. Schnabel

3 (b) If veteran, name war | 3 (c) Social Security Account No. none.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Joseph. 6 (c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) aug 9 1877 ?

8. AGE: Years 66 ? | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home wife.

11. Industry or business

FATHER
12. Name Patrick Mc Namara
13. Birthplace Balto md.

MOTHER
14. Maiden Name Kalderme ?
15. Birthplace Balto md

16 (a) Informant Margaret Williams
(b) Address 1500 Marshall st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer.
Location Baltimore Md.

18 (a) Funeral director George A Weber.
(b) Address 701 S Ann st

19 (a) (Date rec'd by registrar FEB 28 1944) Interrington-Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26th. 1944 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Feb 26 1944 and that I last saw alive on Feb 26 1944

Immediate cause of death: Embolism — Duration 3 days
Due to: Diabetes Mellitus — Duration 3 days
Due to: Natural regurgitation
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Campbell M.D.
Address 1644 Eutaw Date signed 2/26/44

G 14515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14515 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4420 Greenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4420 Greenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine M. French

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. 5. Color or race W. 6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~. Widow

6 (b) Name of ~~husband or wife~~ Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1869

8. AGE: Years 75 Months 1 Days 12 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Homewife

11. Industry or business

FATHER 12. Name John Blairlipp.

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant John E Metzlrowa

(b) Address 512 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Mem Park Location E. North Ave

18 (a) Funeral director John A Moran

(b) Address 3000 E Baltimore St

FEB 28 1944 (Date received by registrar) (b) Huntington Hillsborough, Md.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1944 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April - 1943 to Feb 25 1944 and that I last saw h~~e~~r alive on Feb 24 1944

Immediate cause of death Coronary Occlusion Sudden

Due to Hypertension Arteriosclerosis 1 YR.

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony Florence

Address 5217 York Rd Date signed 3/26/44

G 14516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 14516

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Airquith St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-6883

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Addie Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Baltimore Md
(town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Sparrows Pt

FATHER
12. Name Roger R. Riddick
13. Birthplace N. C.

MOTHER
14. Maiden Name Addie Statham
15. Birthplace N. C.

16 (a) Informant Sadie Taylor
(b) Address 815 Airquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-1944
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Mt. Calvary Md.

18 (a) Funeral director Byron Thomas W. Hughes
(b) Address 721 Pisquith St

19 FEB 28 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1944, at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Arteriosclerotic cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Feb. 26, 1944

G 14517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120

Registered No. G 14517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 N. Mulberry
(c) Hospital or institution: no
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) all her

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Mulberry (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Hill

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Col.	Widower

6 (b) Name of husband or wife: Unascertained
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74	—	—	hr. — min.

9. Birthplace Balto Co. Md. (Town, county, and state)
10. Usual Occupation Laborer (Retired)
11. Industry or business —

FATHER
12. Name —
13. Birthplace Balto Co. Md.

MOTHER
14. Maiden Name Not known
15. Birthplace Balto Co. Md.

16 (a) Informant Mary E. Hawkins
(b) Address 614 N. Mulberry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Baltimore Co. Md.

18 (a) Funeral director Chas. J. Alexander
(b) Address 922 N. Mount St.
(c) Date received FEB 28 1944 (Local Registrar) Huntington Williams Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1944; at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1944 to Feb. 25 1944, and that I last saw h alive on Feb. 25 1944

Immediate cause of death: Senile Debility

Duration
25 days

Due to Age

Due to Infection

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholas Skatoni M. D.
Address 922 N. Mount Date signed 2/27/44

G 14518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 14518

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Keswick Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Keswick Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes Mooney.

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife John Mooney. 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1873

8. AGE: Years	Months	Days	If less than one day
70	6	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER 12. Name Wm. E. Redman.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Mary Brown.
15. Birthplace Maryland.

16 (a) Informant Florence R. Hamilton
(b) Address 2601 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28/44 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director Chenault & Donovan
(b) Address 3615-17 Chestnut Ave Huntingdon Williams, M.D.

FEB 28 1944 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1944, at 6:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 23, 1943 to Feb 24 1944 and that I last saw h[illegible] alive on Feb 24 1944

Immediate cause of death: Chronic Myocarditis

Duration: 1 mo

Due to

Due to

Other Conditions: Arteriosclerosis

Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Richardson

Address 112 W. 25th Date signed Feb 28, 44

G 14519 (Not to be used for Registration)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 14519

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2219 E. Balto St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 E. Balto (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Cohen

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER
12. Name Not Known
13. Birthplace Russia
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-44 (month) (day) (year)
(c) Cemetery or crematory Baltgate
Location Shut Rd & Hamilton Ave

18 (a) Funeral director Jos. Levin
(b) Address 1439 E. Balto St

19 Filed FEB 28 1944 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28/44 19 , at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4th 1943, to 2/17th 1944, and that I last saw h alive on 19

Immediate cause of death: Coronary Occlusion — Duration: 2,

Due to Coronary arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature H. J. Jankin M. D.
Address 100 N. Mulberry Date signed 2/28/44

C 14520

BALTIMORE CITY HEALTH DEPARTMENT

TN. 86552

CERTIFICATE OF DEATH 477

Registered No. C 14520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

7-4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Frank Masopust

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1869

8. AGE: Years	Months	Days	If less than one day
74	5	27 ?	hr min.

9. Birthplace Czechsovakia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Tobi Masopust
13. Birthplace Czechsovkia

MOTHER
14. Maiden Name Mary ?
15. Birthplace Czechslovakia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-44 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore, Md.

18 (a) Funeral director Frank Ovach & Son
(b) Address 900 N. Chester St.

19 (a) FEB 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/44 19.... at 12⁰⁰ NOON

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1944, to 2/24 1944, and that I last saw h~~im~~ alive on 2/24 1944.

Immediate cause of death: Pneumonia RML & RLL
CA - ? lung (?)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: — — — — — —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl P. Kinney M. D.
Address Bal. City Hosp. Date signed 2/24/44

G 14521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 14521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3001 Chelsea Terrace

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3001 Chelsea Terrace (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country No

3 (a) FULL NAME Esther Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years 89 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Jacob

FATHER — 13. Birthplace Russia

MOTHER — 14. Maiden Name Eva

MOTHER — 15. Birthplace Russia

16 (a) Informant Mrs. Cohen (Daughter)

(b) Address 3001 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-44 (month) (day) (year)

(c) Cemetery or crematory Greater Balto. Lodge

Location Hebrew Friendship Rd

18 (a) Funeral director Jos. Lewis Inc

(b) Address 1439 E. Balto. St

FEB 28 1944 (Date received by Local Registrar) (b) Huntington Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1944 at 6:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1944 to 2/26 1944 and that I last saw he/she alive on 2/26 1944.

Immediate cause of death: Acute Cerebral Hemorrhage

Due to Secondary arteriosclerosis

Due to Chr myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. L. Hornstein M. D.

Address 733 Aisquith St Date signed 2/28/44

G 14522

AB-12718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

Registered No. G 14522

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: (If not in hospital, give name of owner)
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs. 4 mos. 27 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Barnes St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Rowley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1855

8. AGE: Years	Months	Days	If less than one day hr.	min.
88	7	11		

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Brickmaker

11. Industry or business

FATHER 12. Name Benjamin

13. Birthplace Maryland

MOTHER 14. Maiden Name Martha Harmon

15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 212 N Schroeder St

19 (a) (Date rec'd by registrar) FEB 28 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1944, at 7:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/44 19.. to 2/25/44 and that I last saw h.. alive on 2/25 1944.

Immediate cause of death: Congestive Heart failure — Duration

Due to Arteriosclerotic C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl P. Kinney M. D.

Address Balt. City Hosp. Date signed 2/28/44

G 14523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G 14523 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.,
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2269 W. Balto. St., Balto Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK EUGENE LYON

3 (b) If veteran, name war: SAW
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Robertson
6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Aug. 19, 1873

8. AGE: Years: 70 | Months: 6 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Providence, R. I. (Town, county, and state)
10. Usual Occupation: ELECTRICIAN
11. Industry or business: Parkway Theatre

FATHER
12. Name: Festus Lyon
13. Birthplace: Conn.

MOTHER
14. Maiden Name: Francis Edwards
15. Birthplace: R.I.

16 (a) Informant: Records-US Marine Hospital
(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Baltimore, Md.

18 (a) Funeral director: Geo. W. Schmidt
(b) Address: 2101 Frederick ave.

FEB 28 1944 (b)
(Date rec'd by registrar) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1944, at 11:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25, 1944, to Feb. 25, 1944, and that I last saw him alive on Feb. 25, 1944.

Immediate cause of death: Arteriosclerotic heart disease with aortic stenosis — Duration: Unk.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [signature] M. D.
Address: US Marine Hospital, Baltimore, Md. Date signed 2/26/44

G 14524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G 14524 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1614 Normal Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1614 Normal Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Henry P. Streb

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-01-8725

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret A.

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) May 4 1896

8. AGE: Years 47 | Months 9 | Days 24 | If less than one day: hr. min

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Lyng Typ Balto News.

11. Industry or business

FATHER 12. Name Adam Streb

13. Birthplace Balto

MOTHER 14. Maiden Name Elizabeth Whitham

15. Birthplace Balto

16 (a) Informant Margaret A. Streb

(b) Address 1614 Normal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)

(c) Cemetery or crematory H. Addemus

Location Baltimore Rd.

18 (a) Funeral director M. W. E. Dropkins Sons

(b) Address 710 Baltimore Rd.

19 (a) FEB 28 1944 (Date received) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1944 to Feb 25 1944, and that I last saw him alive on Feb 25 1944.

Immediate cause of death: Coronary Occlusion — Duration: 15 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Fritz J Schnitzer M. D.

Address 2700 Harford Rd Date signed Feb 26 1944

G 14525 ✓ G 14525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1336 N. Stricker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1336 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country .....

3 (a) FULL NAME Eliza Murray

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Widowed

6 (b) Name of husband or wife Williams Murray
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1889

8. AGE: Years	Months	Days	If less than one day
54	2	3	hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Grooms
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Estella McKenney
(b) Address 1012 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 28 1944 (Date rec'd by registrar) (b) Huntingdon Pa Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1944, at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8-1944 to 2-27-1944 and that I last saw h[illegible] alive on 2-26-1944.

Immediate cause of death: Cardiovascular disease — Duration: ?
Due to .....
Due to .....
Other Conditions Coronary disease
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature John E. L. Camper M. D.
Address 630 N. Carey St Date signed 2-28-44

G 14526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

938

G 14526
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 S. Macon St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 323 S. Macon St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY GEORGE KERNER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 212-03-2808

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Margaret P. Kerner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1891

8. AGE: Years 52 | Months 11 | Days 3029 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Machinest
11. Industry or business Bethlehem Steel

FATHER
12. Name John Henry Kerner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sophia Butzler
15. Birthplace Baltimore, Md.

16 (a) Informant Henry John Kerner
(b) Address 358 Elrino St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore County, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 (a) FEB 28 1944 (Date rec'd by registrar) (b) Huntington Woods, Md. Registrar

VS 180

MEDICAL CERTIFICATION

12.01

20. DATE OF DEATH February 24 1944, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1943, to Feb 24 1944, and that I last saw h alive on Feb 24 1944.

Immediate cause of death Cerebrovascular C.V. disease
Chronic nephritis
Due to Myocardial failure

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

Duration
8-2-43
Feb 17-44

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 5420 Evers Ave Date signed 2-28-44

G 14527

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G 14527
CERTIFICATE OF DEATH 55E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. 46th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SERAFIZA WIITALA

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr John Wiitala
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, y. Nov. 13, 1883

8. AGE: Years	Months	Days	If less than one day
60	3	8	hr. min.

9. Birthplace Finland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Karvi, Mr John
13. Birthplace Finland

MOTHER
14. Maiden Name ? Not known
15. Birthplace Finland.

16 (a) Informant Mr John Wiitala
(b) Address 615 S. 46th St., Balt., Md.

17 (a) Burial (b) Date thereof 3/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Balto. County, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway
Huntington Holliams, Mgr.

19 (a) FEB 28 1944
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944 at 6 ~~AM~~ PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1944 to Feb 26 1944, and that I last saw her alive on Feb 26 1944.

Immediate cause of death Multiple Myelama — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Sellers M. D.
Address Church Home + Hosp Date signed 2-26-44

14528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G 14528 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3042 Dillon St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3042 Dillon St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES THOMAS HOPKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	NONE	M	W	Widower

6 (b) Name of husband or wife Clara S. Hopkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1853

8. AGE: Years	Months	Days	If less than one day hr.	min.
90	8	25		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired 10 yrs. Bricklayer
11. Industry or business Balto. Copper & Smelting

MOTHER / FATHER
12. Name David Hopkins
13. Birthplace Wales
14. Maiden Name Sarah Arnold
15. Birthplace Wales

16 (a) Informant James D. Hopkins
(b) Address 3227 Lake Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE & BROADWAY

FEB 28 1944 (Date received) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH February 26 1944, at 4.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1944 to Feb. 26 1944, and that I last saw him alive on Feb. 25 1944.

Immediate cause of death	Duration
Carcinoma of the liver	1 year
Due to Myocardial insufficiency	19 hrs
Due to Arterio-sclerosis, essential ?	

Other Conditions (Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. B. Bronushas, M. D.
Address 3037 O'Donnell St
Date signed 2-26-44

G 14529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 17c

✓ G 14529
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Frederick County) FREDERICK TRAUTY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Margaret Munser Trauty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1863

8. AGE: Years	Months	Days	If less than one day
78	--	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Upholsterer -retired
11. Industry or business

FATHER
12. Name Andrew Trauty
13. Birthplace Germany

MOTHER
14. Maiden Name Not known
15. Birthplace Germany

16 (a) Informant Mr. Harry T. Krause
(b) Address P.O. Box 63, Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Baltimore, Maryland
HENRY SANDER & SONS, INC.

18 (a) Funeral director
(b) Address North Ave. & Broadway

19 (a) FEB 28 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1944 at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Subdural and epidural Hemorrhage of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 7-1
(a) Date of injury February 19, 1944 M.
(b) Where did injury occur Summer Ave. Nr. Elderry
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Robert L. Fraser M.D.
Medical Examiner.
Date signed Feb. 26, 1944

VS 151

G 14530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 168

G 14530
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 238 S. Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald F Bozman

3 (b) If veteran, name war —
3 (c) Social Security Account No. — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	— —

6 (b) Name of husband or wife — —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1942

8. AGE: Years	Months	Days	If less than one day
2		9	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Donald F. Bozman
13. Birthplace Zanesville Ohio

MOTHER
14. Maiden Name Louise Swift
15. Birthplace Balto, Md

16 (a) Informant Donald F. Bozman
(b) Address 2385. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd

18 (a) Funeral director Thos. L. Keen & Sons
(b) Address Hollins & Gilmor

19 (a) FEB 28 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21-1944, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-21-44 at 1:15 P. M.
(b) Where did injury occur? 238 S. Collington Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Kitchen gas range

23. Signature Howard J. Sheridan M.D.
Medical Examiner.
Date signed 2-23-44

G 14531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G 14531 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 238 S. Collington ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dianne L Bozman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 29 1943

8. AGE: Years	Months	Days	If less than one day
	9	22	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Donald F. Bozman
13. Birthplace Louisville Ohio

MOTHER
14. Maiden Name Louise Swift
15. Birthplace Balto. Md

16 (a) Informant Donald F. Bozman
(b) Address 238 S. Collington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd

18 (a) Funeral director Thos J Kenny
(b) Address Fallsway & Gilmore

19 (a) FEB 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21-44 at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-21-44 at 1:15 P.M.
(b) Where did injury occur? 238 S. Collington ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Kitchen gas range

23. Signature Howard J. Walters M.D.
Medical Examiner.
Date signed 2-23-44

VS 151

PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 14532

PRINT WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.o.A. Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Cedarcroft Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joan Petterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 18, 1873

8. AGE: Years	Months	Days	If less than one day
70	10	9	hr. min.

9. Birthplace Windau Latvia (Town, county, and state)

10. Usual Occupation Boatsman U.S.C.G.S.

11. Industry or business

FATHER
12. Name John Petterson
13. Birthplace Latvia

MOTHER
14. Maiden Name Margaret
15. Birthplace Latvia

16 (a) Informant Mrs. Louis Petterson
(b) Address 606 Cedarcroft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location B.C. Co. Md

18 (a) Funeral director Hyman & Fleming
(b) Address 1426 Light St.

19 (a) FEB 28 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1944, at 8.50 AM

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 2/28/44

14533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14533 Registered No. 1220

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline Street
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. North Point Rd & Wise Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Loretta E. Gawlik

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife JULIUS GAWLIK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 9 1909

8. AGE: Years	Months	Days	If less than one day
34	8	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name JAMES BOCKLAGE
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name MARY ZELLER
15. Birthplace BALTO.MD.

16 (a) Informant JULIUS GAWLIK (HUS.)
(b) Address NORTH POINT RD.& WISE AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB.29/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 FEB 28 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Febrauery 26 1944, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1944 to 2-26 1944, and that I last saw her alive on 2-26 1944.

Immediate cause of death Peritonitis (generalized) — Duration

Due to Partial Intestinal Obstruction

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation 2-22-44

Major findings of operation: Gangrene cecum Large adhesions following a ventrohernioplasty

Findings of autopsy: Gen. peritonitis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Baltrus M. D.
Address St. Joseph's Hosp Date signed 2/26/44

VS 150

14534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 83a

G 14534 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 S.CONKLING ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 S.CONKLING ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE H.PRATT

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 214-16-1534

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced.: DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 22 1886

8. AGE: Years	Months	Days	If less than one day
57	9	4	hr. min.

9. Birthplace NEW HAMPSHIRE (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name MORRIS PRATT
13. Birthplace N.H.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace N.H.

16 (a) Informant EARL PRATT (SON)
(b) Address 1017 S.CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB.29/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 1495 S.WOLFE ST.

19 (a) FEB 28 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB.26 1944 at 11/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1944 to Feb 26 1944.
and that I last saw him alive on Feb 26 1944.

Immediate cause of death: Cerebral Hemorrhage Feb 20 1944
Arteriosclerosis 1944

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Dewar M. D.
Address 35-05 Edgar Date signed 2/27-44

14535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14535
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19d.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 MOS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town ST. HELENA AVE. DUNDALK MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6533 ST. HELENA AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elzie June SHIFFLET

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 8 1943

8. AGE: Years	Months	Days	If less than one day
	5	20	hr. min.

9. Birthplace CHARLOTTESVILLE VA.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name ELZIE SHIFFLET
13. Birthplace VA.

MOTHER
14. Maiden Name LEONA SHIFFLET
15. Birthplace VA.

16 (a) Informant ELZIE SHIFFLET (FATHER)
(b) Address 6533 ST. HELENA AVE.

17 (a) BURIAL (b) Date thereof MAR. 1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CHARLOTTESVILLE CEM.
Location CHARLOTTESVILLE VA.

18 (a) Funeral director Lilly and Giles, INC
(b) Address 403 S. WOLFE ST.

19 (a) FEB 29 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1944 at 1.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1944 to 2/27 1944 and that I last saw h[illegible] alive on 2/27 1944.

Immediate cause of death Lobar pneumonia — Duration 3 wks

Due to Marasmus.

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles D. McDonald M. D.
Address 1213 Light St. Date signed 2-27-44

VS 150

G 14536 Da 6513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G 14536

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da. 3

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 202 S. Eden St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Hudson

3 (b) If veteran, name war: no.

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1888

8. AGE: Years	Months	Days	If less than one day
56	1	0	hr. min

9. Birthplace: Michigan (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: William Hudson

13. Birthplace: Michigan

MOTHER 14. Maiden Name: Caroline Decker

15. Birthplace: Michigan

16 (a) Informant: Records, Baltimore City Hosp.

(b) Address: 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)

(c) Cemetery or crematory: St. Pauls. Original

Location: Sam. Lane.

18 (a) Funeral director: Wendell Dingel

(b) Address: 342 S. Schlander Ave

(Date rec'd by registrar) FEB 28 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1944, at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1944 to 2/26 1944.

and that I last saw h alive on 2/26 1944.

Immediate cause of death: Hanging [illegible] paralytic ileus

Due to: Diss. splenic flexure malignancy

Due to: [illegible] partial

Other Conditions

(Include pregnancy within 3 months of death)

Duration: ed.

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Seigman M.D.

Address BCH Date signed 2/26

G 14537

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 169

G 14537 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Kratz

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-5489

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Cora Bell Kratz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1878

8. AGE: Years	Months	Days	If less than one day
65	3	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Bantgen Bros.

FATHER
12. Name Edward Kratz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Amos
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Cora B. Kratz
(b) Address Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Salem Lutheran
Location Catonsville, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (d) FEB 28 1944 (Date rec'd by registrar) (e) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1944, at 10:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Concussion of brain; pneumonia traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 15, 1944, 11:00 P.M.
(b) Where did injury occur? B. & O. R.R. Ellicott Howard
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Struck by Freight Train

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed February 26, 1944

Please write plainly, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

G 14538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave.
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Elliott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alma Lee Inchliter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	School

6 (b) Name of husband or wife Ruth Alma Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1933

8. AGE: Years	Months	Days	If less than one day
10	7	8	hr. min.

9. Birthplace Groys Md. Elliott City
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Clarence Lee Inchliter
13. Birthplace Virginia

MOTHER
14. Maiden Name Ruth Alma Taylor
15. Birthplace Groys Md.

16 (a) Informant Clarence Lee Inchliter
(b) Address Groys E.C. P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 1 1944 (month) (day) (year)
(c) Cemetery or crematory Taylor TAYLOR Cem
Location Elliott City Md.

18 (a) Funeral director Easton Sons
(b) Address Elliott City Md.

19 (a) 3-2-1944 (b)
Date rec'd by registrar Registrar
Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27-1944, at M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull

Due to

Other Conditions
(include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 27, 1944 4:00 P.M.
(b) Where did injury occur? B & O Railroad Tracks
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Struck by train

23. Signature Howard J. McKenzie M.D.
Medical Examiner.
Date signed 2-26-44

G 14539

BALTIMORE CITY HEALTH DEPARTMENT X 108

CERTIFICATE OF DEATH

Registered No. G 14539

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 5 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 Hammonds Ferry Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Wm. F. Proctor (William F. Proctor)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-05-7232

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Marian L. Proctor
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 9, 1904.

8. AGE: Years	Months	Days	If less than one day
39	8	18	hr. min

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Handyman
11. Industry or business: Beth. Steel

FATHER
12. Name: Richard Proctor
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Segurnia Downs
15. Birthplace: Virginia

16 (a) Informant: Wife Mrs. Marian L. Proctor
(b) Address: 2515 Hammonds Ferry Rd., Lansdowne

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 1, 1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Miller L. Amoreau
(b) Address: 1005 W. Baltimore St.

FEB 28 1944 (Date received) Huntington Williams Jr. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/1944 at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25/1944 to 2/27/1944 and that I last saw h[illegible] alive on 2/27/1944.

Immediate cause of death: Cardiac failure — Duration

Due to: Toxaemia acute Lobar Pneumonia

Due to:

Other Conditions: Arterial Embolism of Left Popliteal vessels
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William J. Bryan M. D.
Address: St Agnes Hospital Date signed: 2/27/44

G 14540

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

91B

Registered No. G 14540

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.,
(c) Hospital or institution:
Baltimore, Md. (U.S. Marine Hospital)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 W. Baltimore, St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK WILLIAM MCINTYRE

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-20-5327

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	Married

6 (b) Name of husband or wife Amelia Teufer McIntyre
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) April 7, 1898

8. AGE: Years	Months	Days	If less than one day
45	10	18	hr. min.

9. Birthplace Farquaire County, Virginia
(Town, county, and state)
10. Usual Occupation Proprietor
11. Industry or business Restaurant

FATHER
12. Name Wm. McIntyre
13. Birthplace Virginia

MOTHER
14. Maiden Name Cora Melton
15. Birthplace Pa.

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Eastern Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Funeral Home
(b) Address 1003 W. Baltimore St.

FEB 28 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25, 1944 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23, 1944 to Feb. 25, 1944, and that I last saw him alive on Feb. 25, 1944.

Immediate cause of death
Acute vegetative endocarditis of aortic valve — Duration: Unk.
Due to Innumerable petechiae hemorrhages, splenic and pulmonary infarcts — Duration: Unk.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature [signature] M. D.
Address US Marine Hospital, Baltimore, Md. Date signed 2/26/44

G 14541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14541 X 53 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Oct. 21, 1943
(e) Length of stay in Baltimore (yrs., mos., or days) Since Oct. 21, 1943

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Chuckatuck (If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM CHRISTOPHER MATHEWS

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillie E. Crumpler
6 (c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) Nov. 19, 1879

8. AGE: Years	Months	Days	If less than one day
64	3	9	hr. min.

9. Birthplace Nansemond County, Va. (Town, county, and state)
10. Usual Occupation Master of ship
11. Industry or business Merchant Seaman

FATHER
12. Name Wm. Thomas Mathews
13. Birthplace Nansemond Co., Va.

MOTHER
14. Maiden Name Julia Hubbard
15. Birthplace Nansemond Co., Va.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Shipped, (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or crematory Suffolk Va
Location Suffolk Va
Fahey Supply
18 (a) Funeral director 1218 Eighth St.
(b) Address
19 (a) FEB 28 1944 (Date rec'd by reg.) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Feb. 28, 1944, at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21, 1943 to Feb. 28, 1944. and that I last saw him alive on Feb. 28, 1944.

Immediate cause of death Terminal bronchopneumonia — Duration 2 weeks

Due to Squamous carcinoma of skin of rt. ear with regional metasta- — Approx. 4 yrs.
~~Entire~~ ses

Other Conditions Osteomyilitis of rt. mandible & skull — Approx. 3 mos.
(Include pregnancy within 3 months of death)

Date of operation 11/15/43-Cautery etc. remnants rt.ear; 1/20/44-Partial resection rt.mandible; Sequestrectomy of mastoid & parietal region; Debridement of rt.parotid region. Findings: as above

Autopsy: None done

PHYSICIAN
Underline the cause which should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J.C.Archer M. D.
Address Baltimore, Md. Date signed 2/28/44

MS-48662

G 14542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G 14542 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Madeson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 904 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Mrs Simmons

6 (b) Name of husband or wife: Wallace Simmons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10-1882

8. AGE: Years 61 62 | Months 4 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Oxford, North Carolina (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER 12. Name Green Horner

13. Birthplace Oxford N.C.

MOTHER 14. Maiden Name Eliza Horner

15. Birthplace Oxford N.C

16 (a) Informant Benjamin F. Horner

(b) Address 904 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-44 (month) (day), (year)

(c) Cemetery or crematory Arbutus Memorial

Location Balto. Co

18 (a) Funeral director J. P. Linthicum

(b) Address 519 Mosher St.

19 (a) ... (b) ... (Signature of local registrar) Registrar

FEB 28 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1944, to Feb 26 1944, and that I last saw h[er] alive on Feb 26 1944.

Immediate cause of death: Cardeo-Renal Hypertension ? — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Horner

Address 1207 N Caroline Date signed 2/27/44 M.D.

G 14543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. G 14543

FILL IN WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Clifton Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James F. Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-3753

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married.

6 (b) Name of husband or wife Anna Schmidt
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1899

8. AGE: Years	Months	Days	If less than one day
44	6	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

FATHER
12. Name Frederick Schmidt
13. Birthplace md

MOTHER
14. Maiden Name Belle —
15. Birthplace —

16 (a) Informant Anna Schmidt
(b) Address 1510 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-44 (month) (day) (year)
(c) Cemetery or crematory Mayslant
Location Baltimore Md.

18 (a) Funeral director Leonard Hardy
(b) Address 2205 Harford Rd

19 (a) FEB 28 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1944, at 10 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1944 to 2/27 1944 and that I last saw h[illegible] alive on 2/27 1944.

Immediate cause of death: Diabetic Coma.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Md. Gen. Hosp. Date signed 2/29/44 M. D.

VS 3

G 14544 G 14544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2904 Rosalie G
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Rosalie G
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Viola E. Heberlein

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex Fm | **5. Color or race** W | **6 (a) Single, married, widowed, or divorced** Married

6 (b) Name of husband or wife Christian Heberlein

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 11-25-1883

8. AGE: Years 60 | Months 2 | Days 27 | If less than one day: hr. ..... min. .....

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Martin F Wurst
13. Birthplace USA

MOTHER
14. Maiden Name Alma Brinkner
15. Birthplace USA

16 (a) Informant Christian Heberlein
(b) Address 2904 Rosalie G

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 2-28-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Leonard Myers
(b) Address 1305 Harford Rd

19 (a) FEB 28 1944 (Date received by registrar) **(b)** Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1944 at 5 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943 to Feb 26 1944 and that I last saw h.. alive on Feb 25 1944.

Immediate cause of death Carcinoma right breast with generalized lymphatic metastasis — **Duration** 2 years

Due to .....

Due to .....

Other Conditions Anasarca

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature N. V. Harbold MD M. D.

Address 4706 Harford Road signed 2/27/44

G 14545

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14545 Registered No. 128

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Ailsa (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Trautwein.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife George Trautwein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2nd 1879

8. AGE: Years	Months	Days	If less than one day
64	8	23	6 hr 15 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name George Sack
13. Birthplace Germany

MOTHER
14. Maiden Name Betty Rau
15. Birthplace Germany

16 (a) Informant Mr. Charles Trautwein
(b) Address 2803 Ailsa Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Loveday Funeral Home
(b) Address 7401 Belair Road

19 (a) Huntington Williams M.D. (Date received by registrar)

FEB 28 1944

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26th 1944, at 6¼ A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24th 1944 to Feb 26th 1944 and that I last saw her alive on Feb 26th 1944.

Duration
Immediate cause of death Acute circulatory collapse — 10 hrs
Due to Acute Hemorrhage Pancreatis — 56 hrs
Due to
Other Conditions Cholelithiasis — ?

(Include pregnancy within 3 months of death)

Date of operation Feb. 24th 1944

Major findings of operation: Swollen pancreas Hemorrhage & Early necrosis.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Berry M.D.
Address Mercy Hospital Date signed 2/29/44

G 14546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14546 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Plymouth Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country

3 (a) FULL NAME John James Roberts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Katherine L.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 27, 1898

8. AGE: Years	Months	Days	If less than one day
45	8	29	hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Jobber
11. Industry or business Quaker Oat Co.

FATHER
12. Name Daniel James Roberts
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Laura Ella Rees
15. Birthplace Balto., Md.

16 (a) Informant Katherine L. Roberts
(b) Address 629 Plymouth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Taylor Ave.

18 (a) Funeral director Wm. J. Tuckner & Son
(b) Address Balto., Md.

FEB 28 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944, to Feb 26 1944, and that I last saw him alive on ..... 19 ....

Immediate cause of death: Coronary occlusion — Duration: 6 wks
Due to: arteriosclerosis — Duration: years.
Due to: .....
Other Conditions: .....

(Include pregnancy within 3 months of death)
Date of operation: .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature William R. Krapf M.D.
Address 10 E. Biddle Date signed 2/28/44

Approved: H. L. Wollenweber M.D. Registrar Feb 28, 1944
Robert Lee Fulton M.D.

G 14547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 14547 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 E. Belvedere Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 E. Belvedere Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ferdinand L. Eidman

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude Reynolds
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 18, 1885

8. AGE: Years 58 | Months 6 | Days 7 | If less than one day: hr. min. 8

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Mfgrs Representative
11. Industry or business

FATHER
12. Name: August Eidman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Kate Schmell
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Gertrude R. Eidman
(b) Address: 1302 E. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) Date received by Registrar: FEB 28 1944 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26. 1944, at 4 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15. 1943 to Feb. 26 1944, and that I last saw him alive on Feb. 24 1944.

Immediate cause of death — Duration

Due to Acute Cardiac Dilatation — few minutes

Due to Coronary Disease — 2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur E. Blake M. D.
Address Med. Arts Bldg. Date signed

C 14548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 14548 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and name town)
(d) Street No. 4302 Walther Blvd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Hutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/1860

8. AGE: Years 83 Months 10 Days 14 If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Pierce
13. Birthplace Virginia

MOTHER 14. Maiden Name Sarah —
15. Birthplace

16 (a) Informant Charles Clifford
(b) Address 4302 Walther Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md.

18 (a) Funeral director Leonard J. Burke
(b) Address 5305 Harford Rd

FEB 28 1944 (Date rec'd by registrar) (b) Name of Undertaker for Williams Mortuary

VS 180 Approved: Robert Lee Prather M.D. Asst. Med. Examiner 3/8/44

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1944, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1944 to Feb 25 1944, and that I last saw her alive on Feb 24 1944

Immediate cause of death Bronchial Pneumonia — Duration 6 days

Due to

Due to Hypertension — 6 years

Other Conditions Fractured Femur — 4 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N/A
(a) Accident, suicide, or homicide Fractured Femur
(b) Date of occurrence Oct 1943 at 9 A.M.
(c) Where did injury occur? 4302 Walther Blvd (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell on floor

23. Signature A. A. Luboff M.D.

Address 5106 Harford Rd Date signed 2-26-44

G 14549 Gankowski 131a G 14549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. COLLINGTON AVE (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hortense He Gankowski

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	MARRIED

6 (b) Name of husband or wife JOSEPH
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 12-25-03

8. AGE: Years	Months	Days	If less than one day hr.	min.
40	2	-		

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name IGNATIUS CIESLINSKI
13. Birthplace POLAND

MOTHER
14. Maiden Name AGNES SMIGLEWSKA
15. Birthplace POLAND.

16 (a) Informant MRS. LILLIAN KACZMAREK
(b) Address 25 N. LAKEWOOD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location MT. CARMEL ROAD.

18 (a) Funeral director M. F. Radowski Mem.
(b) Address 1808 Eastern Ave.

19 (a) (b)
(Signature of Registrar) Registrar

FEB 28 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1944 at 8:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1944 to Feb 25 1944, and that I last saw h[illegible] alive on Feb 25 1944.

Immediate cause of death Acute congestive failure — Duration

Due to Hypertensive C.V.R. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Kijanowski M.D.
Address St Joseph's Hosp Date signed 2/28/44

G 14550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14550 / 83a

Registered No. 3698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 W. Mosher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 W. Mosher St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Florance Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife James Smith
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb 11 1893

8. AGE: Years	Months	Days	If less than one day
51	-	12	hr. min.

9. Birthplace Camden N.J. (Town, county and state)
10. Usual Occupation Home work
11. Industry or business Own home

FATHER
12. Name Wm. Hageman
13. Birthplace N.J.

MOTHER
14. Maiden Name Louise McPherson
15. Birthplace Unknown

16 (a) Informant Mrs. Grant Douglass
(b) Address 7 E 119 St. N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 J Brantley Ave
FEB 28 1944 (b) Huntington Williamsburg
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1944 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1944. to 2-23 1944. and that I last saw her alive on 2-23 1944.

Immediate cause of death	Duration
Cerebral hemorrage	5 days
Due to	
Due to Arteriosclerosis Hypertension	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 029 N. Stricker St. Date signed 2-25-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G 14551~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14551 Registered No. 132

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 13 S. Bond St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Daniel Lucas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1919

8. AGE: Years	Months	Days	If less than one day
24	9	20	hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Daniel Lucas

13. Birthplace W. Va.

MOTHER 14. Maiden Name Berthe Winters

15. Birthplace Pa.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy Wilson

(b) Address 1000 Brantley Ave

19 (a) Date received 2 28 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1944 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1944 to 2/26 1944 and that I last saw him alive on 2/25 1944.

Immediate cause of death: Lobar pneumonia

Due to: Tuberculosis - Pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Biopsy Path. No. of autopsy: Transthoracic femoral phlebectomy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Astor, M. D.

Address Balto. City Hosp. Date signed 2/28/44

M. D.

G 14552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

Registered No. G 14552

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 112 W Perry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days 2 d

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto City (If outside city or town limits, write RURAL and give town)

(d) Street No. 112 Perry St (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Weston Norris

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-6718

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1904

8. **AGE:** Years 40 Months - Days 2 If less than one day hr min

9. Birthplace Va (town, county and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name James Norris

13. Birthplace Va

MOTHER 14. Maiden Name Emma Harris

15. Birthplace Va

16 (a) Informant Weston Norris

(b) Address 112 W Perry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A.A Co MD.

18 (a) Funeral director Isaiah L Brown Son

(b) Address 1086 Montgomery Street

19 FEB 28 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 1944 at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1944 to Feb 20 1944 and that I last saw h alive on Feb 20 1944

Immediate cause of death: Bronchopneumonia

Due to:

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Duration: 3 Months

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James E Fulton M. D.

Address 1310 E. Mary St Date signed 2-25-44

VS 150

G 14553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14553

Registered No. 9-2-D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2231 Christian St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2231 Christian St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Metzger.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louise Metzger

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug 5, 1888

8. AGE: Years	Months	Days	If less than one day
55	6	22	hr min

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name August Metzger

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Stutz

15. Birthplace Germany

16 (a) Informant Mrs Louise Metzger

(b) Address 2231 Christian St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Loudon Park & Edmondson Ave.

18 (a) Funeral director John F. Stewart Sons

(b) Address 901 W. Baltimore St

19 (a) Filed 2-28-1944 (b) Registered by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1944, at 9:50 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1943 to Feb 27 1944, and that I last saw h/ alive on Feb 26 1944

Immediate cause of death: Hypertensive Heart Disease — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. McAllen

Address 3321 Fred. Ave Date signed 2-28-44 M.D.

VS 150

G 14554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14554 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 910 N. Strupe St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a State Md. b County

c City or town Balto.

(If outside city or town limits, write RURAL and give town)

d Street No. 910 N. Strupe St.

(If rural give location)

e Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary G. McNeive

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Michael J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 24th 1865

8. AGE: Years 78 | Months 2 | Days 29 | If less than one day: hr min

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name Patrick McNeive

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary Burns

15. Birthplace Balto.

16 (a) Informant Mrs. Wm. A. Camelin

(b) Address 910 N. Strupe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director C. D. Fanning & Son

(b) Address 1938 E. Lafayette Ave.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.

FEB 25 1944

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1944 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1943 to Feb. 25 1944

and that I last saw h alive on 19

Immediate cause of death

Coronary Thrombosis — Duration 2/23/44

Due to Ch. Myocarditis — 1/1/42

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

d Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

e Means of injury

23. Signature William J. Ryan MD

Address 801 N Kenwood Ave Date signed 2/27/44 M. D.

G 14555

JL - 85570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G 14555

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 W. Lee St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1866

8. AGE: Years	Months	Days	If less than one day
77.	7 6	7 17	hr min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation?

11. Industry or business

FATHER
12. Name William Foster
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Madison
15. Birthplace Md.

16 (a) Informant B. C. H. records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 29. 1944 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Sisly
(b) Address 4049 North Mount Street

28 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1943 to 2/25 1944 and that I last saw h[illegible] alive on 2/25 1944.

Immediate cause of death Cardiac failure

Due to A-S. C.V.D.

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

Duration

PHYSICIAN

I underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergeant D.

Address BCH Date signed 2/25

G 14556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓180

G 14556

Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1326 Hull St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS CADDEN

3 (b) If veteran, name war: no.
3 (c) Social Security Account No. Burial in fed

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Margaret Cadden
6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Dec. 27th 1898

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45 47	2	—		

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Steamship Clerk
11. Industry or business:

FATHER
12. Name: Thomas Cadden
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Nora Durkin
15. Birthplace: Ireland

16 (a) Informant: Margaret Cadden
(b) Address: 1324 Hull St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 1st 1944 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem.
Location: Baltimore Md.

18 (a) Funeral director: Charles F. Dill
(b) Address: 1501 E. Fort Ave

19 (a) Mar 2 1944 (Date received by registrar) (b) Huntington Willis, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27, 1944 at 6 55 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation

Due to House afire

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-27-44 at 6 P 25/1 M.
(b) Where did injury occur? 1324 Hull St
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury: house afire - smoke

23. Signature: H. L. Wallenmeier M.D.
Asst. Medical Examiner
Date signed: 2-28-44

G 14557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G 14557 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2549 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2549 Madison Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Cress

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Joseph Cress

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1883

8. AGE: Years 61 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

MOTHER / FATHER

12. Name Joseph A. Chandlee

13. Birthplace Accomac Co. Va

MOTHER

14. Maiden Name Elizabeth Bailey

15. Birthplace Accomac Co Va

16 (a) Informant Joseph A. Cress

(b) Address 2549 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-44 (month) (day) (year)

(c) Cemetery or crematory Asbury Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. George A. Holland

(b) Address 1631 Druid Hill Ave

19 (a) 2 8 1944 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1944, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1944 to Feb 24 1944 and that I last saw h[illegible] alive on Feb 24, 1944.

Immediate cause of death Carcinomatosis — Duration 6 wks

Due to Carcinoma of Ovary — Duration 6 mos.

Due to

Other Conditions Intestinal Obstruction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen Higgins, M.D.
Address 2543 Madison Date signed Feb 28 1944

VS 1

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G 14558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

G 14558 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4031 ParkHeights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4031 ParkHeights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Kaplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Philip
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation at home
11. Industry or business House Work

FATHER
12. Name Zev Nadol
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Russia

16 (a) Informant Samuel Kaplan
(b) Address 4031 ParkHeights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (b) Registrar

FEB 28 1944

VS 161

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1944, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1943, to Feb 27 1944, and that I last saw her alive on February 27 1944.

Immediate cause of death Paralysis agitans (Parkinson's Syndrome) Arteriosclerosis Acuty gastric dialatation

Duration

Due to

Due to

Other Conditions Asthenia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bny. Kadan M. D.
Address 2306 Eutaw Pl
Date signed 2-28-44

14559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

G 14559
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 20
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 Hollins st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Wain

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76				

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George
13. Birthplace Md

MOTHER
14. Maiden Name Cicion Rom (Cecon R.)
15. Birthplace Md.

16 (a) Informant Wife
(b) Address 2037 Hollins st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore

18 (a) Funeral director Wenderlich & Cole
(b) Address 1200 W Lombard St

19 (a) (Date rec'd by registrar) (b) Huntingtown Hill MD (Registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1944, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Cachexia, Duration
Due to intestinal obstruction
Due to malignancy of lower bowel
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 2/27 Laparotomy
Major findings of operations
of autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William D Layne M. D.
Address U. of. Hospital Date signed 4/4/44

14560
VA-15742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G 14560
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13, 3, 16
(e) Length of stay in Baltimore (yrs., mos., or days) since 1921

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1062 Granby St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Frazier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1882

8. AGE: Years	Months	Days	If less than one day
62 60		6	hr. min.

9. Birthplace Lynchburg, Va.
(Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name William S.
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Beauregard
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-44 (month) (day) (year)
(c) Cemetery or crematory PRESBYTERIAN
Location Lynchburg, Va.

18 (a) Funeral director Hedgepeth & Cole
(b) Address 710 W. Lombard St.

19 (a) FEB 29 1944 (b) Huntington Williams, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1944 at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 2/28 1944
and that I last saw him alive on 2/28 1944

Immediate cause of death Bronchopneumonia (?) Arteriosclerosis coronary occlusion (?)
Due to A-S C.V.D.
Due to
Other Conditions Gen. arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no post

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergeman M.D.
Address B.C.H. Date signed 2/28

G 14561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G 14561 Registered No.

correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 S. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph W. Stevenson
3 (b) If veteran, name war N
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Jeanette Stevenson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 6th 55

8. AGE: Years	Months	Days	If less than one day
86	2	21	hr. min.

9. Birthplace Stokes N.C. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Tournament

FATHER
12. Name Alexander Stevenson
13. Birthplace Scotland

MOTHER
14. Maiden Name Missouri Sizemore
15. Birthplace Stokes N.C.

16 (a) Informant Rosa Holbrunner
(b) Address 23 S. Fulton Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3/1/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1207 St. Paul St.

19 (a) FEB 29 1944 (Date rec'd by registrar) (b) Huntington Printing Co

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1944, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1944 to 2-27 1944, and that I last saw h / m alive on 2-27 1944.

Immediate cause of death: Hypostatic Pneumonia — Duration: 7 days
Due to: Myocardial Weakness
Due to:
Other Conditions: Probable Inj. Hernia-Rt.
(Include pregnancy within 3 months of death)
Date of operation 2-21-44
Major findings of operation: Gall Bl. & Ext. Hemorrhoids & prolapse of Rectum
If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Vogel Jr. M. D.
Address Bon Secours Hospital Date signed 2-27-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1190

G 14562
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2029 W. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2029 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerrell Stith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 12th 1942

8. AGE: Years	Months	Days	If less than one day
1	7	15	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew W. Stith
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Perrell
15. Birthplace Md.

16 (a) Informant Andrew W. Stith
(b) Address 2029 W. Lafayette Ave

17 (a) Burial (b) Date thereof 2/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1207 St. Paul st.

19 (a) FEB 29 1944 Hunting for Williams Bros.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26, 1944 to Feb 27 1944, and that I last saw h/ alive on Feb 27 1944.

Immediate cause of death	Duration
Malnutrition	
Due to	
Due to	
Other Conditions Rickets. Enteritis and Bronchial Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 528 Mulberry St Balto Date signed 2/28/44 M D

14563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

877

Registered No. C 14563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Jail
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Poplar Grove st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E Deitz

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
W	— None	Male	White	Divorced

6 (b) Name of ~~husband or~~ wife Mildred Dietz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22nd 900

8. AGE: Years	Months	Days	If less than one day
44	1	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Unknown

FATHER
12. Name John F. Dietz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mollie C. Voyel
15. Birthplace Germany

16 (a) Informant Mrs. Mazie Cullum
(b) Address 937 W. Franklin st.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/1/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1267 St. Paul st

19 (a) FEB 29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27- 19XX, at 6 XX P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage

Due to

Other Conditions Hypertrophy & arteriosclerosis of Heart & Arteriosclerosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wheeler M.D. Medical Examiner
Date signed 2-28-XX

Please write information asked for carefully and correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G 14564

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 E. Grindall St.
(c) Hospital or institution:

24

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 E. Grindall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie C. Albanson

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband Knut Wm Albanson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17 1888

8. AGE: Years	Months	Days	If less than one day
55	11	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Hooper
13. Birthplace

MOTHER
14. Maiden Name Mary
15. Birthplace

16 (a) Informant Knut W. Albanson
(b) Address 213 E. Grindall St

17 (a) Burial (b) Date thereof 3/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) FEB 29 1944 (b) Washington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1944 at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1943 to 2-27- 1944.
and that I last saw h alive on 2-27 1944.

Immediate cause of death: Cirrhosis of liver (non-alcoholic) — Duration: 4 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. A. Collod M. D.
Address 707 E. Fort Ave. Date signed 2-28-44

14565 Wortche

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D ✓

G 14565 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1522 Mc Henry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 M
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(or) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard L. Wortche

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lottie M. Falck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 25, 1869

8. AGE: Years 74 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Henry Wortche
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Lottie M. Wortche
(b) Address 1522 Mc Henry St

17 Burial (b) Date thereof Feb 29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Nitzke
(b) Address 401 Edmondson Ave

19 FEB 29 1944 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25/44, 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1943. to Feb. 25 19 44.
and that I last saw him alive on Feb. 24 19 44.

Immediate cause of death: Carcinoma Prostate, Bladder, rectum. — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris B. Schreiber M. D.
Address 54 S. Fulton Ave Date signed Feb. 26, 44

G 14566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G 14566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband/wife Charles Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28. 1877

8. AGE: Years 66 Months 7 Days 28 If less than one day hr. min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name Wm. H. Kirkwood

13. Birthplace Md

MOTHER 14. Maiden Name Augusta Scheit

15. Birthplace Md

16 (a) Informant Gilbian Downey

(b) Address 1918 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location 2930 Frederick Rd.

18 (a) Funeral director Harry D. Nitzke

(b) Address 4401 Edmondson Ave

19 (a) Filed FEB 29 1944 (b) Hunting for Williams, M.D.
(Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26/44 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1944 to 2/26 1944, and that I last saw her alive on 2/26 1944.

Immediate cause of death: Myocarditis

Due to: Cholecystitis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 weeks 2 ..

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Adkins M.D.

Address 1945 N. Baltimore Date signed 3/2/44

D. S SHANAHAN

G 14567

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92D

G 14567
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1832 Wilhelm St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1832 Wilhelm St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick C. Kondner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	widowed

6 (b) Name of husband or wife late Caroline nee Dieckman 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14, 1859

8. AGE: Years	Months	Days	If less than one day hr.	min.
84	3	17		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name — Kondner
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant
(b) Address 4404 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Longwood & Edmondson Ave

18 (a) Funeral director Harry A. Wilbur
(b) Address 4016 Edmondson Ave

19 FEB 29 1944 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944 at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1944 to Feb 26 1944 and that I last saw him alive on Feb 24 1944.

Immediate cause of death Coronary Thrombosis — Duration 5 days
Due to Cardiac Arteriosclerosis — 3 Weeks
Due to
Other Conditions Bronchial Asthma — 38 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson, M.D.
Address 3431 Greenmount Ave Date signed 2/28/44

Spec.—9-39—A. & Co.—250 Blks.

V G 14568

14568 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 108

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 N. Lanvale ST. 11-2 WARD)

2-FULL NAME Mary Cosby Bainbridge

(a) RESIDENCE NO. 132 N. Lanvale ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 7 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	99	1	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Louisville Ky

PARENTS
10 NAME OF FATHER Edmund Taylor Bainbridge
11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.
12 MAIDEN NAME OF MOTHER Sophia Daily
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Miss Mary B Stone
(Address) 1415 Boston St

15 Date FEB 29 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 '44

17
I HEREBY CERTIFY, That I attended deceased from Jan ... 1942 ... to Feb 28 ... 1944
that I last saw h alive on Nov 20 ... 1944
and that death occurred, on the date stated above, at 5 30 P m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(duration) ... yrs. ... mos. 1 ds.
CONTRIBUTORY (Secondary) Chr. Myocarditis
(duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Dr.
(Signed) Palmer H. Williams M. D.
2/28 1944 (Address) Pikesville. Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem
DATE OF BURIAL Feb 29 1944

20 UNDERTAKER Henry N. Jenkins & Sons Co
ADDRESS Mc Culloh & Oakland Sts.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 14569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14569 ✓ 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 Edmondson Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Edmondson Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME William W. Dunlap

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of ~~husband~~ or wife: Jennie Dunlap
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1873
8. AGE: Years 70 | Months 6 | Days 8 | If less than one day ... hr. ... min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Drayman
11. Industry or business Retired

FATHER
12. Name Jarrett Dunlap
13. Birthplace Va.

MOTHER
14. Maiden Name Malinda Dunlap
15. Birthplace Va.

16 (a) Informant Lauretta A. Anthony
(b) Address 1016 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director John M. Dorsey
(b) Address 1700 Druid Hill Ave

FEB 29 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1944 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1944 to 2-25 1944 and that I last saw h/M alive on 2/24 1944.

Immediate cause of death: Cerebral hemorrhage — Duration: 10 days
Due to: Hypertensive cardio-
Due to: renal disease
Other Conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raynes Browne M.D.
Address 500 E. Madison St. Date signed 2/26

Raynes Browne

M. D. B. 1200-0

14570 HEALTH DEPARTMENT—CITY OF BALTIMORE 14570

CERTIFICATE OF DEATH 117a

1. PLACE OF DEATH

Registered No. .....

CITY OF BALTIMORE: (No. 2316 Division St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Charles Money

(a) Residence: No. 2316 Division St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Money

6. DATE OF BIRTH (month, day, year): July 8, 1881

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
62	63	7	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Easternshore, Md

FATHER

13. NAME: Charles Money

14. BIRTHPLACE (city or town) (State or country): Easternshore Md

MOTHER

15. MAIDEN NAME: Annie Money

16. BIRTHPLACE (city or town) (State or country): Easternshore, Md

17. INFORMANT: Sarah Money
(Address) 2316 Division St.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Auburn Cem Date 2-28-1944

19. UNDERTAKER: Archibald G. Gaddis
(Address) 2101 W. Baltimore St.

20. FILED FEB 29 1944 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Feb. 26, 1944

22. I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1943 to Feb 26, 1944
I last saw him alive on Feb. 25, 1944. Death is said to have occurred on the date stated above, at 7.25 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Gastric ulcer	4 mos
Uremia - Sclerosis	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Donald Sinclair M. D.

(Address) 2-4 yrs Liberty Title Bldg.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

U. S. 3

14571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14571

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 N Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3241 Pula Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude LANG Lorraine Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Albert Long

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) June 10 - 1888

8. AGE: Years	Months	Days	If less than one day
55	8	17	hr. min.

9. Birthplace Bath. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name Charles P. Nelson
13. Birthplace Md

MOTHER
14. Maiden Name Gerberg
15. Birthplace Md

16 (a) Informant Albert Long
(b) Address 3241 Pula Rd.

17 (a) Burial (b) Date thereof 3/2/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Locust Hill
Location Gorsuch Hill Rd.

18 (a) Funeral director John A. Hoban
(b) Address 3000 E. Balto St.

FEB 29 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1944 to Feb 27 1944, and that I last saw he alive on Feb 27 1944.

Immediate cause of death Acidosis — Duration

Due to Diabetes mellitus Uncontrolled

Due to

Other Conditions Abscess left hand, Acidotic Coma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.

Address St Joseph's Hospital Date signed 2-27-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 14572 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits write RURAL and give town)

(d) Street No. 2011 Harford Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. MARY T. SULLIVAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Daniel Sullivan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1886

8. AGE: Years	Months	Days	If less than one day
57	6	28	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER 12. Name Patrick Costello

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Lafferty

15. Birthplace Baltimore

16 (a) Informant Daniel S. Sullivan Jr.

(b) Address 322 Featherbed Rd. Towson md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/44 (month) (day) (year)

(c) Cemetery or crematory New Cath. Old Frederick Rd.

Location

18 (a) Funeral director John A. Hogan

(b) Address 420 Greenmount ave

FEB 29 1944 Huntington Williams, M.D. Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1944 at 5:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 19xx to 2/28 1944 and that I last saw her alive on 2/28 19 44

Immediate cause of death Respiratory failure

Due to Cerebrovascular Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S L Gray M. D.

Address Mercy Hosp. Date signed 2/29/44

14573 2200 10-11 38 AM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 14573 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 GARRISON BLVD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 GARRISON BLVD. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRIETTA W. COBURN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife THOMAS. COBURN

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) NOV-16-1873

8. AGE: Years 70 | Months 3 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER 12. Name JOHN. H. BURMAN

13. Birthplace GERMANY

MOTHER 14. Maiden Name LOUISA. A LETIMATE

15. Birthplace BALTIMORE MD

16 (a) Informant THOMAS. COBURN

(b) Address 3604 GARRISON BLVD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 1 44 (month) (day) (year)

(c) Cemetery or crematory LORRAIN CEM

Location WOODLAWN MD

18 (a) Funeral director MRS Chas A Roble

(b) Address 2327 EDMONDSON AVE

FEB 29 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 27 1944, at 3 27 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1944, to Feb. 27 1944, and that I last saw h.w. alive on Feb. 27 1944.

Immediate cause of death — Duration

Due to myocardial insufficiency — 10 hrs.

Due to diabetes mellitus, — 8 days

Due to arterio sclerosis — several yrs

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M Burman and Sons

Address 2200 Garrison Blvd Date signed 2/28/44 M. D.

14574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G 14574 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 N. Montford ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 N. Montford ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry G. Heiker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/11/1865

8. AGE: Years	Months	Days	If less than one day
79	96	1417	hr. min.

9. Birthplace Baltimore, Md.
(Town or county, and state)

10. Usual Occupation Saw maker - retired

11. Industry or business

FATHER
12. Name John Heiker
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Leightner
15. Birthplace Baltimore

16 (a) Informant Addie McLanahan
(b) Address 1114 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 2 '44 (month) (day) (year)

(c) Cemetery or crematory Balto Cem
Location Balto Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 2501 Orleans St

19 (a) FEB 29 1944 (Date rec'd by registrar) (b) Huntington for Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28- 1944, at 11:15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Due to
Other Conditions Arteriosclerotic Cardiovascular disease.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 2-29-44

VS 181

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

14575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G 14575

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1527 N Milton

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1527 N Milton Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Theresa Scheid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Henry Scheid

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1877

8. AGE: Years	Months	Days	If less than one day
72	5		hr. min

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name Dont Know

13. Birthplace

MOTHER

14. Maiden Name Dont Know

15. Birthplace

16 (a) Informant George Scheid

(b) Address 1527 N Milton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 1/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Ulman Funeral Home

(b) Address 2008 Oaleum St

19 (a) FEB 29 1944 (Date received by registrar) (b)

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1941 to 2/28 1944, and that I last saw h[illegible] alive on 2/28 1944.

Immediate cause of death	Duration
Terminal bronchopneumonia	2 days
Due to Carcinoma of Stomach	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Matt Bauer M. D.

Address 1501 N. Milton Ave Date signed 2/28/44

14576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G 14576

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hilltop Rd & Caton Ave
(c) Hospital or institution: St Agnes Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Englewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Williamson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex W | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lucy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1874

8. AGE: Years 69 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Jamaica (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER 12. Name Amy H Williamson

13. Birthplace Jamaica.

MOTHER 14. Maiden Name Not Available

15. Birthplace Jamaica

16 (a) Informant Edgar Williamson

(b) Address 311 E Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-44 (month) (day) (year)

(c) Cemetery or crematory Greatan Cem

Location Bush Md

18 (a) Funeral director George G Stanley

(b) Address Catonsville Md

19 (a) FEB 29 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1944, at 11:08 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1944, to 2-27 1944 and that I last saw him alive on 2-27 1944

Immediate cause of death: Adeno-Carcinoma of the Colon with

Due to Metastases to Lymphatic

Due to Nodes.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-26-44

Major findings of operation: Carcinoma of Colon with Metastases to Lymph glands Intestinal obstruction

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D. M. D.

Address St. Agnes Hosp Date signed 2/27/44

C 14577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 14577 Registered No.

122a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 S Payson
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 S Payson (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Casper E Stengel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife: Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10 1862

8. AGE: Years	Months	Days	If less than one day
82		17	hr. min.

9. Birthplace New York (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Adam Stengel
13. Birthplace Germany

MOTHER
14. Maiden Name Magda Veith
15. Birthplace Germany

16 (a) Informant Wm A Stengel
(b) Address 210 S Payson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Berger & Sargent
(b) Address Eutaw & Fayette

19 (a) 2-29 1944 (Date received by registrar) (b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1944, at 3½ P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 30 1944, to Feb 27 1944, and that I last saw him alive on Feb 27 1944.

Immediate cause of death: Acute Cardiac Dilatation — Duration: 1 day

Due to: Chr. Valvular Heart Disease — Duration: ?

Due to: Hypertension Heart Dis

Other Conditions: Strangulated Hernia
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Mezick Jr
Address 1500 E. 33rd Date signed 2/29/44 M. D.

No. 14578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

G 14578 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 916 S. Hanover St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 916 S. Hanover St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marie Paroviaskovia Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Stevenson (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE Years About 65 Months Days If less than one day hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Not known

13. Birthplace

14. Maiden Name Not known

15. Birthplace

16 (a) Informant John Stevenson

(b) Address 916 S. Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Road

18 (a) Funeral director John A. Greblunas

(b) Address 1123 S. Paca St.

19 (a) FEB 29 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1944 at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 44 to Feb. 27 1944.

and that I last saw he alive on Feb. 27 1944.

Immediate cause of death Cardio-Renal Vascular disease

Duration 6 Months

Due to

Due to

Other Conditions Toxic Goitre

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Guy Lanham M.D.

Address 2128 W. North Ave. Date signed 2/29/44

VS 150

G 14579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G 14579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 W. North ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 W. North ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. McMullen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Clarence E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1877

8. AGE: Years	Months	Days	If less than one day
66	8	17	hr. min.

9. Birthplace Richmond Co. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Sisson
13. Birthplace Va.

MOTHER
14. Maiden Name Eliz. Frances Hung
15. Birthplace Va.

16 (a) Informant Clarence E. M. McMullen
(b) Address 2827 W. North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) FEB 29 1944 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/44 19 44, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1944 to Feb 27 1944, and that I last saw h. w alive on Feb 26 1944.

Immediate cause of death Myocardial insufficiency -

Due to Arteriosclerotic type heart dis. with congestive failure

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Years
Months
Days

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel M. D.
Address 2401 Edmondson Ave Date signed Feb 29 1944

G 14580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 14580 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

REMOVE REINFORCED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1904 N. Payson St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mt

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1904 N. Payson St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Christian List

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16, 1866

8. AGE: Years	Months	Days	If less than one day
77	6	11	hr. min.

9. Birthplace Baltimore, Md, (Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business Pennsylvania R.R. Co.

FATHER
12. Name George List
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Burch
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anita List

(b) Address 1904 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 1, 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons,

(b) Address North & Pa. Aves.

19 (a) FEB 29 1944 Huntington Williams, M.D. (Date received by registrar) (Registrar) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to Feb 27 19 44, and that I last saw him alive on Feb 26 1944.

Immediate cause of death: Chronic Nephritis Uremia — Duration: 1 week

Due to Cardio-Vascular disease & hypertension — ?

Due to

Other Conditions Cerebral Hemorrhage — 3 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry Cohmen M.D.

Address 1924 W Northern Date signed 2/28/44

G 14581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 14581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARROW INDICATES FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2637 Miles Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2637 Miles Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Edward W. Twiford (Ford)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1879

8. AGE: Years	Months	Days	If less than one day
65		15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Canton R.R. Co.

FATHER

12. Name Wesley Twiford

13. Birthplace Md.

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Marie Ford

(b) Address 2637 Miles Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2, 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons,

(b) Address North & Pa. Aves.

19 (a) FEB 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27, 1944 at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944 to Feb 27 1944, and that I last saw him alive on Feb 23 1944

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to Cardio-vascular Renal Disease 10 yrs

Due to Rt. lobar pneumonia 4 wks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature V. V. Harlold M.D.

Address 4716 Harford Rd Date signed 2/28/44

14582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 14582 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1404 Northgate Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Northgate Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Albert Lynch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife M. Edna Lynch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6, 1891

8. AGE: Years	Months	Days	If less than one day
53	0	22	20 hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Asst. Mgr.

11. Industry or business General Ship Repair

FATHER
12. Name Henry B. Lynch
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Caroline Elizabeth Albert
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. M. Edna Lynch
(b) Address 1404 Northgate Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Wm. J. Luckyn & Son
(b) Address Balto., Md.

19 (a) FEB 29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1944, at 8 P. M

21. I certify that I took charge of the remains described above, held an inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Waldeck M.D. Medical Examiner
Date signed 2-29-44

VS 151

Please write clearly. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 14583 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 W. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 W. Hoffman St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie J. Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8. 1881

8. AGE: Years 62 | Months 4 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John H. Smith
13. Birthplace Md

MOTHER
14. Maiden Name Emma Lee
15. Birthplace Va

16 (a) Informant Mrs Ethel Harris
(b) Address 531 W. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md

18 (a) Funeral director Mc Francis A. Hemsley
(b) Address 571 W Biddle St

19 (a) ... (b) ... (Date received by registrar) FEB 29 1944 (Registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1944 at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 26 1944 to Feby 27 1944, and that I last saw h[illegible] alive on Feby 26 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Viola Smith M. D.

Address 844 N. Carey St Date signed 2/28/44

G 14584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G 14584 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5103 Oaklawn Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5103 Oaklawn Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William G. Shaffer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alta Faye Shaffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1878

8. AGE: Years	Months	Days	If less than one day
65	10	10	hr. 19 min.

9. Birthplace Manchester, Md. (Town, county, and state)
10. Usual Occupation Linesman
11. Industry or business Western Union Telegraph Co.

FATHER
12. Name George Wm. Shaffer
13. Birthplace Manchester, Md.

MOTHER
14. Maiden Name Sarah Bixler
15. Birthplace Manchester, Md.

16 (a) Informant Mrs. Alta Faye Shaffer
(b) Address 5103 Oaklawn Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director W. Howard Strong
(b) Address 3207 W. North Ave.

FEB 29 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1944, at 4.10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941, to Feb 27 1944 and that I last saw him alive on Feb 27 1944

Immediate cause of death: Carcinoma Jaw — Duration

Due to Hypernephroma — 3 years

Due to Arterio Sclerosis — 5 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Sanford M. D.
Address 4509 Roland Ave Date signed Feb 28

G 14585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14585 — 12/a — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 E. 22nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Olive D. DeVine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife James B. Divine | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10 - 1868

8. AGE: Years 75 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER 12. Name Chas. Michel

13. Birthplace France

MOTHER 14. Maiden Name Rose Wills

15. Birthplace Baltimore Md.

16 (a) Informant Miss Estelle St Laurent

(b) Address 709 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 29, 1944 (month) (day) (year)

(c) Cemetery or crematory Forest Lawn

Location Buffalo Co. N.Y.

18 (a) Funeral director Robert S. Little

(b) Address 710 Edmondson Ave

19 (a) 29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

FEB

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1944 at 3.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 26 1943 to Feb 28 1944, and that I last saw h[illegible] alive on Dec 7 1944.

Immediate cause of death — Duration

Due to Chr. Myocarditis 1935

Due to Chr. Interstitial Nephritis 1935

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jane Brown

Address 1634 North Ave. Date signed 2/29/44 M. D.

G 14586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 14586 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N Schroeder
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Schroeder
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21-1881

8. AGE: Years 62 | Months 9 | Days 13 4 | If less than one day hr. min.

9. Birthplace Abbottsville Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Green Ramsay
13. Birthplace S C.

MOTHER 14. Maiden Name Laura Gray
15. Birthplace S C.

16 (a) Informant Lillian Higgins
(b) Address 110 N. Schroeder

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 1-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto Co

18 (a) Funeral director Saml. H Chase & Son
(b) Address 638 N. Gilmor St
FEB 29 1944 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 25 1944 at 10.30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944 to Feb 25 1944 and that I last saw her alive on Feby 24 1944.

Immediate cause of death	Duration
Cerebral Apoplexy	5 day
Due to Hypertensive Renal	4
Due to Vascular Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. B. Harell M. D.
Address 601 N. Arlington Ave Date signed 2/29/44

VS 150

G 14587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 14587 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2229 E.Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED: Md.
(a) State (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 E.Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

9-14

3 (a) FULL NAME Charles E.Burgan

3 (b) If veteran, name war	3 (c) Social Security Account No. 216-102-124

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margeret C.Burgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.14-1886

8. AGE: Years	Months	Days	If less than one day
58	11	12	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Mill Wright
11. Industry or business

FATHER
12. Name Charles E. Burgan
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Clara V. Trumbo
15. Birthplace Balto. Md.

16 (a) Informant Burial Margeret C.Trumbo
(b) Address 2229 E.Chase

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof *Feb.Mar.1-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave. & Gay St.

18 (a) Funeral director John A. Miller
(b) Address 2211 Jefferson St.

19 (a) [illegible] Huntington Williams M.D. Registrar
(Date rec'd by registrar) FEB 29 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1944, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1944, to Feb 26 1944, and that I last saw h[illegible] alive on Feb 26 1944.

Immediate cause of death Coronary Thrombosis — Duration 4 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokoryny M.D. M. D.
Address 2200 E Madison St. Date signed 2/28/44

FEB 29 1944

14588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 6

Registered No. G 14588

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORY RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 W. Ostend (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEWART, Evelyn ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Bl	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1941

8. AGE:

Years	Months	Days	If less than one day
2	6	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name James Gray
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Dorothy Stewart
15. Birthplace Baltimore

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Ebon Wilson
(b) Address 1000 Brantley Ave

19 (a) (b) Huntington Williams M.D. Registrar

FEB 29 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1944, at 8:38 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 19 44, to Feb 26 19 44, and that I last saw her alive on Feb 26 19 44.

Immediate cause of death — Duration

respiratory failure

Due to meningococcemia — 2 d.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 2-27

14589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 14589 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 717 E. Biddle St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 717 E. Biddle St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patricia Ann Casparriello

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1940

8. AGE: Years	Months	Days	If less than one day
3	8	20 21	hr. min.

9. Birthplace Baltimore, Maryland (city, county, and state) None

10. Usual Occupation

11. Industry or business

FATHER 12. Name Anthony Casparriello

15. Birthplace Italy

MOTHER 14. Maiden Name Anita Quillin

15. Birthplace Baltimore, Maryland

16 (a) Informant Anthony Casparriello

(b) Address 717 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Mar. 1, 1944

(c) Cemetery or crematory New Cathedral Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Flynn and Fleming

(b) Address 1426 Light St.

19 (a) Filed (Month) (Day) (Year) FEB 29 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to Feb. 28 1944, and that I last saw her alive on Feb. 28 1944.

Immediate cause of death Cerebral Hemorrhage — Duration hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph S. Blinn M.D.

Address 1206 E. Preston St. Date signed 2/29/44

14590 G 14590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

Registered No.

TN. 86409

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Grayson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race C

6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife Estella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31, 1895

8. AGE: Years 48 | Months 4 3 | Days 24 | If less than one day hr. min.

9. Birthplace Washington D. C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Grayson (D
13. Birthplace ?

MOTHER
14. Maiden Name Mary ? (D
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St Huntingtown Williams, Md.

FEB 29 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1944 at 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1944 to 2/25 1944 and that I last saw him alive on 2/25 1944.

Immediate cause of death Subacute bacterial endocarditis, pulmonary emboli, multiple

Due to Strep. viridans on pneumococcus vegetations on tricuspid valve

Duration 2 wks ?

Other Conditions Purulent meningitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature E. L. Sergmon M. D.

Address BCH Date signed 2/26

G 14591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14591 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 N Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N Schroeder (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Land

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas Land

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5, 1897

8. AGE: Years 47 | Months — | Days 20 | If less than one day hr. min.

9. Birthplace Chester S.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Dolphin Worthy
13. Birthplace Chester S.C.

MOTHER 14. Maiden Name Hattie Head
15. Birthplace Chester S.C.

16 (a) Informant Thomas Land
(b) Address 120 N Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 29 1944 (Date rec'd by Registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 25 1944 at 1:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1943 to Feb 25 1944 and that I last saw her alive on Feb 20, 1944

Immediate cause of death: Tuberculous Peritonitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Howell M. D.
Address 601 N Carrollton Ave Date signed 2/29/44

VS 150

G 14592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14592 / 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 510 N. Eden St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 510 N. Eden St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓

If yes, name country

3 (a) FULL NAME Emma Cathey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Cathey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9 1898

8. AGE: Years 45 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Dallen, S. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Frank Galt.

13. Birthplace S. C.

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Henry Cathey

(b) Address 510 N Eden

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy Wilson

(b) Address 1005 Biddle Lane

19 (a) Date received by registrar FEB 29 1944 (b) Huntington Williams, M.D. Registrar

VS III 44

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1944 at 9:7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1944 to 2/24 1944 and that I last saw h[er] alive on 2/24 1944

Immediate cause of death: Bronchopneumonia — Duration 21 days

Due to: Bleeding End Tuberculosis

Due to: Bronchitis

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jas R. Blake M. D.

Address 132 N. Central Date signed 2/29/44

G 14593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 14593

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 914 Boyd Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 914 Boyd Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary J Tilghman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1884

8. AGE: Years	Months	Days	If less than one day
60	-	4	hr. min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name John Edmund Jones

13. Birthplace Md

MOTHER 14. Maiden Name Anne Smith

15. Birthplace Md

16 (a) Informant Ella Miller

(b) Address 1117 W Lexington St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)

(c) Cemetery or crematory Madison Md

Location

18 (a) Funeral director Sarah L Brown Son

(b) Address 1058 W Montgomery St

19 (a) Filed FEB 29 1944 (b) Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1944 to Feb 26 1944 and that I last saw h[illegible] alive on Feb 26 19 44.

Immediate cause of death Bronchopneumonia — Duration 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm H. Watts M. D.

Address 515 Cathedral Date signed 2/29/44

G 14594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14594 Registered No.

46E

*PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 LOUDON AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 YEAR

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 LOUDON AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM CHRISTY

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife LULA P. CHRISTY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1870

8. AGE: Years 74 | Months | Days | If less than one day: hr. min.

9. Birthplace SMITHS ISLAND MD. (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name JOHN CRISTY
13. Birthplace MD.

MOTHER
14. Maiden Name MARY MARSHALL
15. Birthplace MD.

16 (a) Informant LULA P. CRISTY (WIFE)
(b) Address 126 LOUDON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 2/44 (month) (day) (year)
(c) Cemetery or crematory CRISFIELD
Location CRISFIELD MD.

18 (a) Funeral director John J. Bradshaw.
(b) Address CRISFIELD MD.

19 (a) FEB 29 1944 Huntington Williams, M.D. Registrar
VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH FEB. 29 1944 at 1/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1944 to Feb 29 1944. and that I last saw h[illegible] alive on Feb 27 1944.

Immediate cause of death: Intestinal Obstruction — Duration: 2 Weeks

Due to Carcinoma of Colon — 7 Years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M. D.

Address 343 Dulaney Date signed 2/29/44

G 14595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14595 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hanney Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D:a:A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Mc Alear Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isabella Mc Cullough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry S. E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1881

8. AGE: Years	Months	Days	If less than one day
62	11	17	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Benjamin Homberger
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Waltrum
15. Birthplace Baltimore, Md

16 (a) Informant Henry J. E. Mc Cullough Jr.
(b) Address ~~Hdc~~ 1101 Mc Alear Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 2 44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 2 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1944, at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to Generalized arteriosclerosis, advanced.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb. 29, 1944

VS 151

Please answer all questions. Physicians: please write the causes of death clearly and legibly.

G 14596

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14596 Registered No. 186 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bethlehem-Fairfield
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Q. A.
(c) City or town Brooklyn Park (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Edgewood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William A. Greene

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/1885

8. AGE: Years 58 | Months 10 | Days 14 | If less than one day hr. 7 min.

9. Birthplace Galts. Md. (Town, county, and state)

10. Usual Occupation Rigger Bethlehem Fairfield

11. Industry or business Beth. Fairfield Shipyard Co.

FATHER
12. Name Benjamin F. Grant
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Parkson
15. Birthplace Maryland

16 (a) Informant Mrs. Ethel Laucht
(b) Address 3439 Cliftmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 2 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Wm Cook Dir.
(b) Address 1817 St. Paul St.

19 (a) 2-9-1944 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1944, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 28, 1944 2:15 P.M.
(b) Where did injury occur? Bethlehem-Fairfield
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? Yes
(d) Means of injury Struck + crushed by Beams

23. Signature Robert L. Fraser M.D. Medical Examiner.
Date signed Feb. 24, 1944

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14597 / 186a

Registered No.

XA-86662

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 Garrett Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Schreiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Julius (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1862

8. AGE: Years	Months	Days	If less than one day
81	5 M	29	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

MOTHER / FATHER
12. Name Ludwig Geise
13. Birthplace Germany
14. Maiden Name Dorothy ?
15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1944, at 5.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1944, to 2-27 1944, and that I last saw her alive on 2-27 1944.

Immediate cause of death

Coronary Occlusion — Duration: hrs ?

Due to Generalized Arteriosclerosis — 24 hrs ?

Due to Fracture Neck Rt Femur

Subcutaneous Hge

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation:

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide Accidental Fall
(b) Date of occurrence 2-25-44 at City M
(c) Where did injury occur? Balto (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? Home (Specify type of place) While at work? No
(e) Means of injury Accidental Fall in Home

23. Signature Donald Bissett M. D.
Address Balto City Hosp Date signed 2-28-44

For Dr. Hyman Molomut by Howard J. Sheeler, M.D.

G 14598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 14598 / 1579

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Univ. Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d.
(e) Length of stay in Baltimore (yrs., mos., or days) 5d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Hyde Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Amos

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
		5 Days	hr. min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Rev. Howard M. Amos
13. Birthplace Md.

MOTHER
14. Maiden Name Fanetyne A. Dehlin
15. Birthplace Penna

16 (a) Informant Rev. H. M. Amos
(b) Address Hyde Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 1-1944 (month) (day) (year)
(c) Cemetery or crematory Fork M. E. Cem.
Location Fork Md.

18 (a) Funeral director Clarence E. Luther
(b) Address Fork Md.

19 (a) (City registrar) (b) Huntington Williams, M.D.

FEB 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1944 at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1944 to Feb 28 1944, and that I last saw her alive on Feb 28 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Congenital Atresia of duodenum and common bile duct, Cerebral	5 days
Due to hemorrhage, Atelectasis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations See above
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. V. Latimer Jr. M. D.
Address Univ. Hosp. Date signed 2-28-44

G 14599

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14599 / 107

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 John street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 John street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME JEAN BERNADETTE ERDMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
----	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Single

6 (b) Name of husband or wife ----
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 28, 1937

8. AGE: Years	Months	Days	If less than one day: hr	min.
6	9	--		

9. Birthplace Camden, N.J. (Town, county, and state)
10. Usual Occupation School-girl
11. Industry or business

FATHER
12. Name John B. Erdman
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Audrey C. Hall
15. Birthplace Columbus, Ohio

16 (a) Informant John B. Erdman
(b) Address 1512 John street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MARCH 2-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location .....

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

FEB 29 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1944 to 2-28 1944.
and that I last saw h[illegible] alive on 2-28 1944

Immediate cause of death

Duration

Bronchio Pneumonia — 3 da.

Due to

Due to cardiac dilatation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature Thurlet C. Blake M. D.
Address Med. Arts Bldg. Date signed

14600 — 14600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette St.
(c) Hospital or institution: Franklin Square Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 day
(e) Length of stay in Baltimore (yrs., mos., or days) 7 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Franklin Square Hosp, 2512 Frederick Ave (Street and number)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Baby Girl Harris

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2 Feb

8. AGE: Years	Months	Days	If less than one day
		7	hr. min.

9. Birthplace Balto. Md. Franklin Sq. Hosp. (Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name George Edward Harris
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Ethel Patricia Bodlit
15. Birthplace Balto. Md

16 (a) Informant .....
(b) Address .....

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location JOHN HOPKINS MEDICAL SCHOOL FEB 29 1944

18 (a) Funeral director Commissioner of Health
(b) Address .....

FEB 29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25-44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19-44 19 , to 2-25-44 19 , and that I last saw h alive on 2-25-44 19 .

Immediate cause of death
Prematurity 11-lbs
Due to 11-lbs

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

Duration .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Duncan Clyde Webster
Address Franklin Square Hosp. Date signed 2/25/44

VS 3

L0755

G 14601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 14601

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 530 N. Robinson St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 29 Belnord Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Annie E. Mattson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of ~~husband~~ or wife Wm H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3 1874

8. AGE: Years 68 Months 10 Days 23 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name Raymond Graff

13. Birthplace Germany

MOTHER 14. Maiden Name Emilia Kempa

15. Birthplace Baltimore Md

16 (a) Informant Wm H Mattson

(b) Address 530 N Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)

(c) Cemetery or crematory Oak Hill

Location Eastern Ave Rd

18 (a) Funeral director John G Moran

(b) Address 3800 E Baltimore St

19 (a) FEB 29 1944 (Date received by registrar) (b) Registrar

Hunter for Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3/43 1943 to 2/26 1944, and that I last saw h-[illegible] alive on 2/25 1944.

Immediate cause of death [illegible] Duration [illegible]

Due to [illegible] 2 yrs

Due to [illegible] 4 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 2-29-44

G 14602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 142 B

G 14602

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 Etting St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3 (a) FULL NAME Edna Hilda Jackson

3 (b) If veteran, name war ..... | 3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	married

6 (b) Name of husband or wife Robert Jackson
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 19, 1906

8. AGE: Years	Months	Days	If less than one day
37	8	6	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business .....

FATHER
12. Name Harry Huffins
13. Birthplace Md.

MOTHER
14. Maiden Name Edna Smith
15. Birthplace Balto. Md.

16 (a) Informant Robert Jackson
(b) Address 2017 Etting St.

17 (a) Burial (b) Date thereof 9-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 (a) AUG 29 1944 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1944 at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death Hemorrhage + shock

Due to abdominal pregnancy full term

Due to Premature separation of the placenta (abruptio)

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: Abdominal preg. 7 premature separation left tubal

of autopsy: none

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature D.M. Dixon M. D.
Address Provident Hospital Date signed .....

JL - 8663 G 14603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G 14603
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
4940 Eastern Ave.
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 S. Curley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Schroll

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Doris Schroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1918

8. AGE: Years	Months	Days	If less than one day
25	9	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name Henry Schroll
13. Birthplace Md.

MOTHER
14. Maiden Name Rose Loeher
15. Birthplace Md.

16 (a) Informant B. C. H Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof March 1 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Road

18 (a) Funeral director Rendell & Dugal
(b) Address 12. S. Highland Ave

19 (a) FEB 29 1944 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1944, at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944, to 2/26 1944, and that I last saw him alive on 2/26 1944.

Immediate cause of death Laceronial hemorrhage; uremia — Duration 5 hr

Due to H & V D; essential hypertension

Due to

Other Conditions Congenital lues

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergmon M. D.
Address D C H Date signed 2/26

G 14604 Nov 9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14604 Registered No.

AB-86442

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3411 Foster Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5-1865

8. AGE: Years	Months	Days	If less than one day
78	9	23	hr min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Davis

13. Birthplace ?

MOTHER 14. Maiden Name Mary Adra

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Donnell St

18 (a) Funeral director Arnold J. Koppel

(b) Address 312 S. Highland Ave

19 (a) (Date rec'd by registrar) (b) (Registrar)

FEB 29 1944 Hattie Lee Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1944, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1944, to 2-28 1944, and that I last saw h alive on 2-28 1944.

Immediate cause of death

Bronchopneumonia — Duration: 2 days

Due to

Due to Fracture neck of Rt femur — 16 da

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-22-44

Major findings of operation: Fracture femur

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence February 12, 1944

(c) Where did injury occur? Highland Ave + 2nd St (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Public Place While at work? No (Specify type of place)

(e) Means of injury Slipped + fell on ice

23. Signature Donald Bolitt M.D.

Address Balto City Hosp Date signed 2-28-44

To be approved by the Medical Examiner Approved: Howard Lee Frantum M.D. 3/4/44

G 14605

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14605 Registered No. 93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. Md
(b) Street address 4110 Groveland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4110 Groveland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice H. Fitch

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry W. Fitch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3rd 1863

8. AGE: Years	Months	Days	If less than one day
80	9	26	hr. min.

9. Birthplace Minneapolis, Minn. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernst F. Heyd
13. Birthplace Germany

MOTHER
14. Maiden Name Martha B. Evans
15. Birthplace Penna

16 (a) Informant Mrs. R. Halliday
(b) Address 4110 Groveland Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mch 1 - 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director H. Brooks Bradley Inc
(b) Address 1922 N. Monte Ave

19 (a) 3 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29/44 19 . at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943. to Feb 28 1944. and that I last saw h-- alive on Feb 26 1944.

Immediate cause of death Myocarditis
Due to Arteriosclerosis
Due to
Other Conditions External dilitation of esophagus congenital
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration about 6 mo.
9

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fallen J. Kilbyt M. D.
Address 2220 Garrison Blvd Date signed Feb. 29/44

G 14606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G 14606 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1312 SO. Highland Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1312 S. Highland Ave. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin F. Burke Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-1165

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Martha L. Reckenberger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 4, 1893

8. AGE: Years	Months	Days	If less than one day
50	11	22	hr. min.

9. Birthplace A. A. Co. Md (Town, county, and state)

10. Usual Occupation Chauffeur [illegible]

11. Industry or business Hechts Reliable

FATHER 12. Name Benjamin F. Burke Sr.

13. Birthplace Va.

MOTHER 14. Maiden Name Willenna Drury

15. Birthplace A. A. Co. Md.

16 (a) Informant Wife

(b) Address 1312 S. Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)

(c) Cemetery or crematory National

Location Frederick Rd

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway

MAR 1 - 1944 Huntington Williams M.D. Registrar

(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 26 1944 at 11.45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1943 to Feby 26 1944. That I last saw h alive on Feb 26 1944.

Immediate cause of death Cardiac paralysis

Carcinoma Prostate &

general carcinomatosis

Duration about 3 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. V. Clark M. D.

Address 5010 Greenleaf Road Date signed 2/28/44

G 14607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G 14607 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 143 N. Lakewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 143 N. Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Julia C. Schwartz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife William H Schwartz 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1846

8. AGE: Years	Months	Days	If less than one day
97	4	13	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Andrew J. Bandel
13. Birthplace Baltimore

MOTHER 14. Maiden Name Annie E. Chandler
15. Birthplace Baltimore

16 (a) Informant Mrs J.W. Hamilton
(b) Address 143 N. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount & Oliver

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) MAR 1 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 19 44 to Feb 27 19 44, and that I last saw her alive on Feb 27 19 44.

Immediate cause of death
Terminal Pneumonia with Pulmonary Edema
Due to Chronic nephritis
Due to Chronic thyrocolitis

Duration
2 days
4 yrs
" "
)

Due to Carcinoma of facial skin
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo Dr Lipton M. D.
Address 432 S. Patterson Pk Date signed 3/2/44

G 14608

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 457

G 14608
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 Mosher St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Wyatt
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary B
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1891
8. AGE: Years 52 | Months | Days | If less than one day hr. min.
9. Birthplace: Va (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business

FATHER
12. Name John C. Wyatt
13. Birthplace Va

MOTHER
14. Maiden Name Manerva Chapel
15. Birthplace Va

16 (a) Informant: Patsy
(b) Address 1424 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Robert E. Williams
(b) Address 15-17 N. Eutaw St

19 (a) MAR 1 - 1946 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1946 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1946, to 2/27 1946, and that I last saw h- alive on 2/26 1946.

Immediate cause of death: Carcinoma Jaw
Due to: Pain
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burkett M. D.
Address 733 Dumbarton Ave Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G 14609

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 14609 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Welsh

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Harford County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Patrick
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Flaherty
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Erin
Location Stapper & Graef

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) MAR 1 - 1944 (Date rec'd by registrar) (b) Registrar Huntington Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1944 at 7.15 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 - 1944, to Feb 29 - 1944, and that I last saw her alive on Feb 28 - 1944.

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Wall M. D.
Address 1631 E North Ave Date signed 2/29/44

14610

Ja 86357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G 14610
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 ds.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 Valley St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William McDermott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1874

8. AGE: Years	Months	Days	If less than one day
69	7	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation On Pension

11. Industry or business

FATHER
12. Name Thomas McDermott
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Reynolds
15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) 3-1-1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1944, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 1944 to 2/28 1944, and that I last saw h[im] alive on 2/28 1944.

Immediate cause of death Bronchopneumonia — Duration 0

Due to

Due to

Other Conditions A.S. CVD; Anemia
CVD (?)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No part

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sayman M. D.
Address BCH Date signed 4-25

G 14611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182

G 14611

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Veronica Love

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Single —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 8, 1943

8. AGE: Years	Months	Days	If less than one day: hr	min
	10	19		

9. Birthplace A. A. Co., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Long
13. Birthplace N. C.

MOTHER
14. Maiden Name Zelma Carter
15. Birthplace Md.

16 (a) Informant Matilda Chase
(b) Address 1326 Argyle Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 3-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md

18 (a) Funeral director James A. Hayes
(b) Address 1942 W. Pratt St

MAR 1 - 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27- 1944, at 7 to P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-27-44 at P. M.
(b) Where did injury occur? 1326 Argyle ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Found drowned.

23. Signature Howard J. Waldeck M.D.
Medical Examiner
Date signed 2-28-44

G 14612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 121a

G 14612 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2535 N. Howard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 N. Howard St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Lester Cole

3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-01-9210

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Essie T. Cole
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) February 11, 1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52	-	14		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clothes Packer
11. Industry or business Rubber Clothes Company

FATHER
12. Name John Henry Cole
13. Birthplace Virginia

MOTHER
14. Maiden Name Eliza Howard
15. Birthplace Virginia

16 (a) Informant Mrs. Essie T. Cole
(b) Address 2535 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Maryland

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Avenue

MAR 1 - 1944 (Date rec'd by registrar) (b) Hunting for Holland Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1944, at M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1 1943 to Feb. 25 1944, and that I last saw him alive on Feb. 25 1944.

Immediate cause of death: Cardiac Renal Disease — Duration: 9 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2529 E. [illegible] Date signed Feb. 28 1944 M. D.

G 14613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14613 Registered No. 121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2319 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2319 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Otta M. Cuttings

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1903

8. AGE: Years 40 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Bayside, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Noah Lewis
13. Birthplace Bayside, Va.

MOTHER
14. Maiden Name Mary Taylor
15. Birthplace Bayside, Va.

16 (a) Informant Howard C. Cuttings
(b) Address 2319 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Centura
Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Hallal
(b) Address 163 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Hunting & Williams

MAR 1 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1944 at 7:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1 1942 to Feb 22 1944, and that I last saw h[er] alive on Feb. 20 1944.

Immediate cause of death Cardio Renal Disease — Duration 1 yr 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. D. Jolleman M.D.
Address 2029 Eutaw Pl. Date signed Feb 28 1944

G 14614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 943 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 943 W. Fayette St. (If rural give location)
e Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Arthur Gilliam
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-18-4649
4. Sex Male
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Catherine Gilliam
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 18, 1899
8. AGE: Years 45 Months — Days 8 If less than one day hr min
9. Birthplace Columbus, Ohio (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Catherine Gilliam
(b) Address 943 W. Fayette St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.
19 (a) MAR 1 - 1944 (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 2[illegible] - 1944 at 1130P, M

21. I certify that death occurred on the date above stated, that I attended deceased from 2 - 24 - 1944, to 2 - 2[illegible] - 1944, and that I last saw h[illegible] alive on 2 - 2[illegible] - 1944

Immediate cause of death	Duration
Bronco-Pneumonia	3 days
Due to Bronchitis	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which place)
(e) Means of injury
23. Signature McDonald Landon M D
Address [illegible] Date signed 3-1-44

14615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G 14615
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Marlborough Apts.
(b) Street address Eutaw Place & Wilson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. Eutaw Place & Wilson St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Nathan L. Solmson

3 (b) If veteran, name war None

3 (c) Social Security Account No. 214-03-3436

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Paulina M. Solmson

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr July 17, 1881

8. AGE: Years 62 | Months 7 | Days 11 | If less than one day hr min

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Branch Mgr.

11. Industry or business Homeland Tailors Inc.

FATHER
12. Name Herman Solmson
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah June
15. Birthplace Baltimore

16 (a) Informant Mrs. Paulina M. Solmson
(b) Address Marlborough Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 2, 1944 (month, day, year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address Baltimore, Md.

19 (a) Date received MAR 1 - 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28, 1944 at 8:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 2-28 1944.
and that I last saw h alive on Acute Coronary

Immediate cause of death

Acute Coronary thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury

23. Signature Bernard Cohn

Address Marlborough Date signed 2/29 W D

G 14616

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1942

G 14616
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Guilford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Hannah J. McErlain

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Bernard J.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20, 1864
8. AGE: Years 79 | Months 8 | Days 8 | If less than one day: hr. min

9. Birthplace: Ireland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: William Desmond
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Ellen Hayes
15. Birthplace: Ireland

16 (a) Informant: Mrs. Bernardine J. Crew
(b) Address: 1612 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 2, 1944 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves.

19 (a) (Signature of local registrar) (b) Registrar

MAR 1 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1944, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1941, to Feb 28 1944, and that I last saw her alive on Feb 28 1944

Immediate cause of death	Duration
Myocardial Degeneration with bundle branch block	2½ yrs.
Due to arterial Hypertension	10 yrs
Due to arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, etc.) While at work?
(e) Means of injury
23. Signature William J Draughty M. D.
Address 106 Biddle St Date signed 3/3/44

G 14617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 14617 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6421 Glenoak Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 6421 Glenoak Ave.
(If rural, give location)

(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Sarah C. Collins

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Oliver C. Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1875

8. AGE: Years	Months	Days	If less than one day
69	0	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Charles Clark

13. Birthplace Not Known

MOTHER 14. Maiden Name Catherine Wilhelm

15. Birthplace Not Known

16 (a) Informant Mrs. Thelma P. Stroh

(b) Address 6421 Glenoak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1, 1944 (month, day, year)

(c) Cemetery or crematory Lorraine Park Cem.

Location Woodlawn, Balto. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.

(b) Address North & Pa. Aves.

Date received MAR 1 - 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1944, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 5 1944, to Feb 28 1944, and that I last saw h alive on Feb 27 1944

Immediate cause of death

Due to Coronary Thrombosis

Due to Arteriosclerosis

Other Conditions Cholecystitis

(Include pregnancy within 3 months of death)

Duration
½ hr.
1 yr.
1 yr.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Edw C Pyeatt M.D.

Address 1 W. Chase St. Date signed 2/28/44

G 14618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14618
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. Garland St
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible]
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Wilfred [illegible] Fuller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8, 1[illegible]

8. AGE: Years	Months	Days	If less than one day
20	0	20	hr. min.

9. Birthplace [illegible] Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name William Henry Fuller
13. Birthplace Balto. Co. Maryland

MOTHER
14. Maiden Name Martha V. Fuller
15. Birthplace Balto. Co. Maryland

16 (a) Informant Mrs Rose L. Fuller
(b) Address Joppa Rd. Fullerton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25th 1944 (month) (day) (year)
(c) Cemetery or crematory Mass Methodist
Location Parkville, Md.

18 (a) Funeral director Leasdon Funeral Home
(b) Address 7401 Belair Road

MAR 1 - 1944
(Date rec'd by local Registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH [illegible] 19[illegible] at 2:21 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 19[illegible], to Feb 28 19[illegible], and that I last saw h[illegible] alive on Feb 28 19[illegible].

Immediate cause of death [illegible] pneumonia
[illegible] and [illegible] failure

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Feb 28, 19[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G 14619

CERTIFICATE OF DEATH 48 B

G 14619

Reg. Dist. No.

1. PLACE OF DEATH:

City or town: Baltimore Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 4121 Mark Pl

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town [illegible] Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. [illegible]

(If rural give LOCATION)

2 a) IF VETERAN, NAME WAR

3. (a) FULL NAME Katherine Virginia [illegible]

3. b) Social Security Number [illegible]

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W.	widowed

6 (b) Name of husband or wife Frederick William [illegible]

deceased 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 23 - 1873

8. AGE: Years	Months	Days	If less than one day
71	0	6	hrs min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name John Wm. Virgin

13. Birthplace Balto

MOTHER 14. Maiden name Louise Reigelt

15. Birthplace Rockwood N.J.

16. Informant Mr. & Mrs. John Wm. Virgin

Address 4121 Mark Pl.

17. Buried (Burial, cremation, or removal) Mar 3/44 (month) (day) (year)

Cemetery or crematory Baltimore

Location Balto Md

18. Funeral director Philip Henry Sons

Address 2024 Eutaw St.

19. MAR 1 - 1944 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20 DATE OF DEATH -2-24- 1944 about 5:30 am

21 I CERTIFY that death occurred on the date above stated, that I attended deceased from JAN 19- [illegible] to - 24 - 1944 and that I last saw h[illegible] alive on 2-23- 1944

Immediate cause of death — RESPIRATORY FAILURE — DURATION

Due to CARCINOMA ULCERATING CARCINOMATOUS INVOLVEMENT — 5 days

Due to CARCINOMA SPINE METASTASIS — 3-4 yrs

Other conditions NONE (Include pregnancy within 3 months of death)

Major findings of operations SAME

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22 VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Victor Richards M. D. or other

Address Date signed

0

14620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

G 14620

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1316 Eutaw Place, city

(c) Hospital or institution: Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1316 Eutaw Place (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Herman Caroline Rockford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1878

8. AGE: Years	Months	Days	If less than one day
65 yrs	5	09	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Mr. George Rhine Sahn (D)

13. Birthplace Maryland

MOTHER 14. Maiden Name Alida Shriver (D)

15. Birthplace Maryland

16 (a) Informant Mrs. Alice Stabler

(b) Address 1316 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 2/44 (month) (day) (year)

(c) Cemetery or crematory Mt Christian Burial Location Joppa Harford Co Md

18 (a) Funeral director Deaver & Foster

(b) Address Bel Air Md

19 (a) MAR 1 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29, 1944 at 8 1/2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 29 1944 to Feb 28 1944 and that I last saw h[illegible] alive on Feb 28, 1944

Immediate cause of death Resp. failure due to Uremia — Duration 1 mo.

Due to Tuberculosis of Kidneys, rt + Lft — 16 yrs.

Due to

Other Conditions Chr. Pulmonal abscess, rt — Diabetes Mellitus — 15 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stephen J. Van Lill III M. D.

Address Union Memorial Hosp Date signed 2-29-44

D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14621

8 3a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 Lyndhurst St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Lyndhurst St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Summers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Ellen O'Day Summers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1865

8. AGE: Years	Months	Days	If less than one day
79	-	1	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Cigar Filler

FATHER
12. Name John Summers
13. Birthplace Md

MOTHER
14. Maiden Name Anne Londuman
15. Birthplace Md

16 (a) Informant Mrs. Ellen Summers
(b) Address 917 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A. Little
(b) Address 401 Edmondson Ave

19 (a) MAR 1 - 1944 (Date received by registrar) Hunting for Williams (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944. to Feb 27 1944.
and that I last saw him alive on Feb. 27 19 44

Immediate cause of death: General debility — Duration 2 mos.
Due to Cerebral hemorrhage — 7 yrs.
Due to Arterio-sclerosis — 10 yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Wells M. D.
Address 4100 Edmondson Ave Date signed 3/1/47.

WELLS

14622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 14622
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Leo St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME antoinette or Antoinissa Sokolis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Bala
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Wallace Sokolis
(b) Address 3714 Leo. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Hermon Hill Rd.

18 (a) Funeral director Wm. S. Fiallkowske
(b) Address 2007 Eastern ave

19 (a) MAR 1 - 1944 (Date rec'd by registrar) Huntington Tallmans, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1944, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 29 1944

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 14623

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170C

G 14623 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 N. Regester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	School Boy

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4th 1934

8. AGE: Years	Months	Days	If less than one day
9	5	23	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name James E. Kennedy
13. Birthplace Md

MOTHER 14. Maiden Name Catherine Baldwin
15. Birthplace Md

16 (a) Informant James E. Kennedy
(b) Address 1517 N Regester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2nd 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N Patt Park Ave

19 (a) MAR 1 1944 (b) [illegible]

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27-1944, at 9:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured cervical vertebra (Broken Neck)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 27, 1944 8:45 P.M.
(b) Where did injury occur? Essex, Md. Baltimore Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Struck by two autos

23. Signature Howard J. McGrath M.D.
Medical Examiner.
Date signed 2-28-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14624

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 14624
Registered No.

CERTIFICATE OF DEATH 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 Cumberland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Cumberland A
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Harris

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Bertha Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1879

8. AGE: Years	Months	Days	If less than one day
55	-	10 14	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Julius Harris
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Cook
15. Birthplace Md.

16 (a) Informant Bertha Harris
(b) Address 602 Cumberland A

17 (a) Burial (b) Date thereof 3/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Calvert Co. Md
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pennsylvania Ave

MAR 1 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1944, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1944 to Feb 27 1944 and that I last saw him alive on Feb 27 1944.

Immediate cause of death	Duration
Cardio Vascular Disease	1 yr.
Due to Broken Compensation	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Frey M. D.
Address 1928 Pa Ave Date signed 3/1/44

VS 150

14625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

14625 ✓ G

Registered No. .....

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Mulliken Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Dampson Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1924

8. AGE: Years	Months	Days	If less than one day
22	5	10	..... hr. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Bessie Walker
15. Birthplace Va.

16 (a) Informant Lucille Williams
(b) Address 1720 Mulliken St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 2/44 (month) (day) (year)

(c) Cemetery or crematory .....
Location Farmville Virginia

18 (a) Funeral director Mrs. Robert Elliott & Dgt
(b) Address 1129 N. Carolina St.

19 (a) 3-1-1944 (Date rec'd by registrar) (b) Hunting on Horseback 0 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27-1944 at 9.45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Gun Shot of Brain

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-27- at 9.45 P. M.
(b) Where did injury occur? 1720 Mulliken Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Bullet wound of head.

23. Signature Howard J. Cleveland M.D.
Medical Examiner.
Date signed 2-28-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G 14626
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Valentine

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-0362

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Henrietta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1886

8. AGE: Years	Months	Days	If less than one day
57	5	15	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business

FATHER 12. Name John Valentine
13. Birthplace Va.

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Henrietta Valentine
(b) Address 1404 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1 44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Daughter
(b) Address 1129 N. Caroline Street

19 (a) MAR 1 - 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1944 at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1944 to Dec 26 1944, and that I last saw him alive on Dec 26 1944.

Immediate cause of death: Carcinoma of Stomach

Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Harmon

Address 127 N Carlin's St Date signed 2/23/44

Hunting for Williams

G 14627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154 B

G 14627

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1502 Division St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1502 Division St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Robert Peters

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-4834

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Mar

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1910

8. AGE: Years	Months	Days	If less than one day
34	1	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Treasurer

FATHER 12. Name Joseph Henry Peters

13. Birthplace Virginia

MOTHER 14. Maiden Name Rebecca Cahill

15. Birthplace Virginia

16 (a) Informant Mrs Rebecca Peters

(b) Address 1502 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/44 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cem

Location

18 (a) Funeral director Chas H Burkett

(b) Address 521 Lanvale St

MAR 1 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1944, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to Feb 29 1944, and that I last saw him alive on Feb 24 1944.

Immediate cause of death	Duration
Nephritis	3 mo
Due to Abscess of jaw	10 days
Due to	
Other Conditions Arthritis	3 mo.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Douglas Shepperd M. D.

Address 1431 W Franklin Date signed 2/29/44

G 14628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 14628 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2709 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 White Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred M. Bender, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife XXX

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1891

8. AGE: Years	Months	Days	If less than one day
53 yrs.	-	26	hr. min.

9. Birthplace Port Deposit, Md.
(Town, county, and state)

10. Usual Occupation Maintainance Man

11. Industry or business Washington Apts.

FATHER
12. Name Alfred Bender
13. Birthplace Philadelphia Pa.

MOTHER
14. Maiden Name Mary Long
15. Birthplace Philadelphia, Pa.

16 (a) Informant Virginia Kelly (sister)
(b) Address 2709 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (month) (day) (year)
(c) Cemetery or [illegible] Moreland Memorial
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MAR 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1944, at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1941 to Feb 26 1944 and that I last saw h in alive on Feb 26 1944

Immediate cause of death Chronic Nephritis — Duration 6 mos
Due to Chronic myocarditis — 2½ yrs.
Due to Hypertension — 2½ yrs.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 621 Harford Rd Date signed 3/28/44 M. D.

Balts 14

G 14629
JL - 86659

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 57E

✓ G 14629
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hodpitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11h 10m
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Sarah Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1910

8. AGE: Years 33 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business Maryland Bolt &Nut Co.,

FATHER
12. Name George Douglas
13. Birthplace ?

MOTHER
14. Maiden Name Allie ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Interring for Williams, M.D.

MAR 1 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1944 at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1944 to 2-27 1944 and that I last saw h[illegible]live on 2-27 1944

Immediate cause of death: Tracheal Obstruction
Due to Mediastinal Tumor
Due to Probably aneurysm of ascending aorta

Duration
3 da
?
?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-26-44

Major findings of operation: Tracheotomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B. Lett M. D.
Address Balto City Hosp Date signed 2-27-44

G 14630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14630 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 S. Ellwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 52

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 S. Ellwood ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME John Ladzinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emelia Ladzinski 1885

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Labor Retired

11. Industry or business

FATHER 12. Name Casimier Ladzinski

13. Birthplace Poland

MOTHER 14. Maiden Name Eleonore Kasperska

15. Birthplace Poland

16 (a) Informant Emelia Ladzinski

(b) Address 1203 S. Ellwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2/44 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1944, at 9 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1943 to Feb. 27 1944 and that I last saw h[illegible] alive on Feb. 27 1944.

Immediate cause of death Acute Pulmonary Edema — Duration 1 day

Due to Cardiac Asthma — 6 mo.

Due to Chronic Myocarditis — 3 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Szczerbicki M. D.

Address 1802 Eastern Ave Date signed 2-27-44

Szczerbicki

G 14631 — Transmitted G 14631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto General - D.U.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1441 Reynolds St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adam Trawinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Widower

6 (b) Name of husband or wife Frances Trawinski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 17 1882

8. AGE	Years	Months	Days	If less than one day
	61	5	10	hr min

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name Unknown

FATHER — 13. Birthplace Poland

MOTHER — 14. Maiden Name Unknown

MOTHER — 15. Birthplace Poland

16 (a) Informant Mrs. Helen Daughter

(b) Address 1526 Latrobe Park Towers

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/44 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem.

Location Baltimore County

18 (a) Funeral director John F. Welsh

(b) Address 401 S. Chester Street

19 (a) 3-1944 (Date rec'd by registrar) (b) [illegible] Registrar

MAR

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1944 at 6.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ——— at ——— M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury ———

23. Signature [illegible] M.D. Medical Examiner.
Date signed 4/5/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 14632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G 14632 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution: WBGH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BABY McFARLAND

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28-1944

8. AGE: Years	Months	Days	If less than one day
		1	21 hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Hubert McFarland
13. Birthplace Va

MOTHER 14. Maiden Name Elizabeth Davis
15. Birthplace Va

16 (a) Informant Hubert McFarland
(b) Address 1802 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 March 44 (month) (day) (year)
(c) Cemetery or crematory St Mary's Woodlawn
Location Roland Ave

18 (a) Funeral director Dulaney Eck
(b) Address 1217 St Paul St

19 (a) (Date received by registrar) (b) Harrington Williams M.D. Registrar

MAR 1 1944

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/29 1944 at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1944 to 2/29 1944
and that I last saw h / 2 alive on 2/29 1944

Immediate cause of death Total Atelectasis — Duration

Due to

Due to

Other Conditions Hydrocephalus
Recto-Schisis
(Include pregnancy within 3 months of death)

Date of operation 2/29/44

Major findings of operation: A
Recto-Schisis

of autopsy: Atelectasis, Hydrocephalus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 2/29/44 at 7:20 P.M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. N. Friedman M. D.
Address WBGH Date signed 3/1/44

G 14633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 14633 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2751 Winchester St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2751 Winchester St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James F. Grimes

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-5307

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Myra

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20 1885

8. AGE: Years	Months	Days	If less than one day
58	5	9	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER

12. Name Charles Grimes

13. Birthplace Maryland

MOTHER

14. Maiden Name Rovenia Oler

15. Birthplace Maryland

16 (a) Informant Mrs Myra Grimes

(b) Address 2751 Winchester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/44 (month) (day) (year)

(c) Cemetery or crematory Loraine

Location Woodlawn

18 (a) Funeral director William M Mareck

(b) Address 715 Light St

(a) MAR 1 - 1944 (Date rec'd by registrar) (b) Thurlington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29th 1944, at 9:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944 to Feb 29 1944 and that I last saw him alive on Feb 29 1944.

Immediate cause of death Chronic cardio renal disease — Duration 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ernest L. Salem

Address 1731 Pop Av Et Date signed 2/1/44

14634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14634
Registered No.

AB-86565

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 S. Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Phillips

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-? 60 ?

8. AGE: Years	Months	Days	If less than one day
60?	?	?	hr min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar
0759

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21 1944 at 3:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1944 to 2/21 1944.
and that I last saw h alive on 2/21 1944.

Immediate cause of death Cerebral hemorrhage
Due to H.C.V.D.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 36 hr. ?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman M. D.
Address BCH Date signed 2/25

14635

G 14635

JL - 86343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 531 Mosher St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1880

8. AGE: Years	Months	Days	If less than one day
63	2 3	7	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name Will Williams

13. Birthplace Md.

MOTHER

14. Maiden Name Mary ?

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL MAR 1 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1944, at 0392 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1944, to 2-19 1944, and that I last saw him alive on 2-19 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mattus M. D.

Address B. C. H. Date signed 2/22/44

VS 180

10758

G 14636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 14636 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 536 S. Lehigh Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 536 S. Lehigh St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura V. Bonner.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widowed

6 (b) Name of husband or wife John E. Bonner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1872

8. AGE: Years	Months	Days	If less than one day
72	-	18	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER 12. Name Elija H. Gray
13. Birthplace Maryland

MOTHER 14. Maiden Name Ida Cole
15. Birthplace Maryland

16 (a) Informant Robert D. Gray
(b) Address 2837 Brendon Ave, Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3 1944 (month) (day) (year)
(c) Cemetery or crematory Elkton
Location Elkton Maryland

18 (a) Funeral director H. W. Pippin & Son
(b) Address Elkton, Maryland

19 (a) Date received MAR 1 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944 at 6 P AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1944 to March 1 1944. and that I last saw her alive on Feb 29 1944.

Immediate cause of death
Cardiac Failure
Hypostatic Condition Pneumonia
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 257 E Eastern Ave Date signed

G 14637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14637 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied.) The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) since 12/1/43

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 W. 27th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME OLLIE FRANK WHEELER 10/8/42-2/28/43

3 (b) If veteran, name war World's War #2

3 (c) Social Security Account No. 415-34-0964

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Div.

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1900

8. AGE: Years	Months	Days	If less than one day
43	2	4	hr. min.

9. Birthplace Miami, Mo. (Town, county, and state)
10. Usual Occupation Fairfield - 2/18/44
11. Industry or business Shipbuilding

FATHER
12. Name Chas. Wheeler
13. Birthplace Quincy, Ill.

MOTHER
14. Maiden Name Eliza Huff
15. Birthplace ? Mo.

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-44 (month) (day) (year)
(c) Cemetery or crematory
Location Chattanooga Tenn

18 (a) Funeral director A. Lee Elder
(b) Address 4644 York Rd.

19 (a) Filed MAR 1 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Feb. 27, 1944, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23, 1944 to Feb. 27, 1944 and that I last saw him alive on Feb. 27, 1944

Immediate cause of death Acute toxic myocarditis, hepatitis, splenitis & nephritis — Duration: Terminal

Due to Rt. upper lobar pneumonia in the stage of Grey hepatization — Duration: Terminal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris Silverman, (O.D.) M. D.
Asst Surgeon (R)
Address Baltimore, Md. Date signed 2/28/44

Va-14328

G 14638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14638 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Fremont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin F. Hulse

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-12-3612

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29-1886

8. AGE: Years	Months	Days	If less than one day
57	7	25	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Restaurant

FATHER
12. Name James H Hulse
13. Birthplace Balto

MOTHER
14. Maiden Name Mary J Sleet
15. Birthplace Balto

16 (a) Informant Mrs Estella M Haze
(b) Address 824 Braeside Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Rd.

18 (a) Funeral director R. Lee Oder.
(b) Address 4647 York Rd.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1944, at 8:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. J. Wollenweber M.D.
Medical Examiner.
Date signed 2-24-44

VS 151

Write age if infant under 1 year. Physicians: please write the causes of death clearly and legibly.

G 14639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 14639

Registered No.

PRINTED WHEN FILLING, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument & Rutland

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1610 N. Milton ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1944

8. AGE: Years	Months	Days	If less than one day
			5 hr. 2 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name William Simpson

13. Birthplace Hollidaysburg, Pa.

MOTHER — 14. Maiden Name Mazie Gould

15. Birthplace Baltimore, Md.

16 (a) Informant Mazie Simpson

(b) Address 1610 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2nd 1944 (month) (day) (year)

(c) Cemetery or crematory Balto

Location E North Ave Ext

18 (a) Funeral director Leo G. Loock

(b) Address 1701-03 N. Patt Park ave

19 (a) (Date rec'd by registrar) (b) [illegible] Washington Blvd Baltimore MD

MAR 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to March 1 1944, and that I last saw her alive on March 1 1944

Immediate cause of death	Duration
Immaturity	
Due to C. 7 month pregnancy	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Raymond B. Goldberg M. D.

Address Sinai Hosp. Date signed 3-1-44

G 14640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G 14640
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2610 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2610 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Kaiser

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-6036

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Bessie V. Kaiser nee Braun

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1884

8. AGE: Years	Months	Days	If less than one day
59	5	28	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Retired Butcher

11. Industry or business

FATHER
12. Name Henry J. Kaiser
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Louise Walter
15. Birthplace Balto. Md

16 (a) Informant Mrs. Bessie V. Kaiser
(b) Address 2610 Washington Blvd

17 (a) Burial (b) Date thereof 3/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Harry A. Wilson
(b) Address 4101 E. Monument Ave

19 (a) MAR 2 - 1944 (b) Huntington Williams, M.D.
(Date received by reg.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28-1944 at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to 2-28-44.
and that I last saw h[illegible] alive on 2-28-1944

Immediate cause of death
Cancer of Oesophagus — Duration: 7 Months
Due to
Due to
Other Conditions Starvation — Duration: 1 Day

(Include operations within 3 months of death)
Date of operation Radium Therapy
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard D. Kaiser M. D.
Address 2610 Washington Blvd Date signed 3/1/44

G 14641 443389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

X V G 14641

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State TENN (b) County
(c) City or town Knoxville (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 WOODRUSH AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor H Sutherland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife GRACE

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 1-2-78

8. AGE: Years	Months	Days	If less than one day
66	1	27.	hr. min.

9. Birthplace Wisc. (Town, county, and state)

10. Usual Occupation SALESMAN

11. Industry or business

FATHER
12. Name Ellis Sutherland
13. Birthplace Wisc.

MOTHER
14. Maiden Name EMMA PIERCE
15. Birthplace N.Y

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-1-44 (month) (day) (year)

(c) Cemetery or crematory
Location Salisbury Cemetery

18 (a) Funeral director Wm J Fahnestock & Son
(b) Address North & Penna Ave

19 (a) MAR 2 - 1944 (Date rec'd by registrar) (b) Baltimore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1943, to Feb 29 1944, and that I last saw him alive on Feb 29 1944.

Immediate cause of death Arteriosclerotic Cardiovascular Disease.

Due to Benign Prostatic Hypertrophy.

Due to Diverticulitis of colon with rupture + peritonitis

Due to Subphrenic abscess

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 1943; Nov. 1943

Major findings of operation: Same

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randall B. Roth

Address Johns Hopkins Hosp. Date signed M D 3/9/44

VS 180

G 14642

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

168

G 14642 Registered No.

1. PLACE OF DEATH: St. John Lane - Elliott City Md.
(a) Baltimore City, Maryland
(b) Street address Unknown
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Unknown County
(b) City or town Unknown (If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Unknown White Female

3 (b) If veteran, name war

3 (c) Social Security Account No. Single

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 1? | If less than one day: hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 2, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City Md.

19 (a) MAR 2 - 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 29 1944, at 2:40 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Amputation of perineum and lower extremities

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb 29, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14643

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14643
Registered No. 326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 Val. Lanvale a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 W. Lanvale (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mahala Bacon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Widowed

6 (b) Name of husband or wife: Thos Bacon
6 (c) If alive, give age years

7. Birth date of deceased (month, day, year): June 1870

8. AGE: Years	Months	Days	If less than one day
74	1		hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Thos Mansberg
13. Birthplace Md

MOTHER 14. Maiden Name Millie Parker
15. Birthplace Md

16 (a) Informant Edson Richmond
(b) Address 1423 Goodknight a

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo G. Kelson
(b) Address 1303 Presstman St

MAR 2 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 19 44 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 to Feb 28, and that I last saw alive on 2/26/44

Immediate cause of death Pneumonia — Duration 4 days

Due to Influenza

Due to age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunter Williams M. D.
Address 724 Madison Date signed 3/1/44

G 14644

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 14644 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2313 Allendale Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Allendale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella E. Kurtz

3 (b) If veteran, name war: N

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ Lewis T. Kurtz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24th 1858

8. AGE: Years	Months	Days	If less than one day: hr.	min.
86	0	7		

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name Henry S. Lawson
13. Birthplace Alexandria Va.

MOTHER
14. Maiden Name Virginia S. Landeman
15. Birthplace Balto. Md.

16 (a) Informant Lewis T. Kurtz
(b) Address 2313 Allendale Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAR 2 - 1944 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1st 1944. 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1944 to March 1, 1944 and that I last saw her alive on Feb. 29, 1944.

Immediate cause of death	Duration
Myocarditis (chronic)	4 yrs
Due to Arteriosclerosis	?
Due to	
Other Conditions Cerebral hemorrhage	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Penn M.D.
Address 514 Druid Lane Date signed 3/1/44

G 14645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 14645 Registered No. 122a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christiana Trefilis

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband ~~or wife~~: Andrew Trefilis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): abt 1870
8. AGE: Years 74 | Months | Days | If less than one day: hr. min.
9. Birthplace: Kythera, Greece (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business: Self

FATHER
12. Name: Unknown
13. Birthplace: Greece

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Shira E. Conomos
(b) Address: 3201 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Woodlawn
Location: " Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul st.

19 (a) MAR 2 1944 (Date rec'd by registrar) (b) Huntington Willia Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-29-44, at 4:NM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25-1944 to 2-29 1944 and that I last saw her alive on 2-29 1944.

Immediate cause of death	Duration
Acute Myocardial Failure	
Due to Myocarditis + Uremia	
Due to Renal failure	
Other Conditions Post-operature Strangulated Hernia	

(Include pregnancy within 3 months of death)

Date of operation 2-25-44
Major findings of operation: Strangulated umbilical hernia
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Lange M. D.
Address New Haven 2-29-44 Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

14646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 14646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 1 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 Piedmont Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Elizabeth Kuhn Martin

3 (b) If veteran, name war N | 3 (c) Social Security Account No. N G N F

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband Edwin M. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 19 1856

8. AGE: Years 87 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace South America (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Lilburn P. Kuhn
13. Birthplace Buckingham Co. Va.

MOTHER
14. Maiden Name Rachel A. Mills
15. Birthplace Balto Md

16 (a) Informant Marian L. Kuhn
(b) Address 3323 Piedmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/44 (month) (day) (year)
(c) Cemetery or crematory St. Michaels
Location Howard Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) D 2 - 1944 (Date rec'd by registrar) (b) Interim Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1944 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944 to Feb 29 1944 and that I last saw her alive on Feb 29 1944.

Immediate cause of death Heart failure
hypostatic pneumonia — Duration

Due to Arterio Sclerosis CV disease

Due to

Other Conditions Fractured left humerus
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence February 23rd 1944
(c) Where did injury occur? 3322 Piedmont Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Slipped and fell on floor

23. Signature [illegible] M. D.
Address [illegible] Date signed 2-29-44

VS 3

For B.H.L. Wollenweber by Howard J. Andersen M.D.

PERSONS MAKING ENTRIES WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No. G 14647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 N. Highland St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. Highland St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSALIE SALLIE DAVIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Gustavus Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 3, 1881

8. AGE: Years	Months	Days	If less than one day: hr.	min
62	4	26		

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business self

FATHER
12. Name — Clemmens
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Margaret Collette
15. Birthplace Balto, Md

16 (a) Informant Henry Davis
(b) Address 3402 E. Fairmount Ave.

17 (a) Burial (b) Date thereof 3-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto, Md.

18 (a) Funeral director Wm Cook, Inc
(b) Address 1217 St. Paul St

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1944, at 4 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenmann M.D.
Medical Examiner.
Date signed 3-1-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 B

G 14648 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1430 E Monument St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 E Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie Keeley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Married

6 (b) Name of husband or wife Dennis Keeley
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Major Russell
13. Birthplace Md

MOTHER
14. Maiden Name Sallie Hutchins
15. Birthplace Md.

16 (a) Informant Dennis Keeley
(b) Address 1430 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 3 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Brooklyn A.A. Co

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St.

19 (a) MAR 2 - 1944 (Date rec'd by Registrar) (b) Registrar Hilliard M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1944 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Feb 28 1944, and that I last saw her alive on Feb 27 1944.

Immediate cause of death Mitral Insufficiency — Duration 6 mos

Due to

Due to

Other Conditions Chronic Nephritis & generalized Anasarca — 6 mos
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young

Address 1429 E Monument St Date signed 2/29/44 M. D.

M. D. B. 1203-0

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 14649

CERTIFICATE OF DEATH

61

G 14649

1. PLACE OF DEATH

Registered No. .....

CITY OF BALTIMORE: (No. 2222 W. Fayette St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Elmer Paul Hipsley

(a) Residence: No. 2222 W. Fayette St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Hipsley

6. DATE OF BIRTH (month, day, year) Dec. 20, 1898

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45	2	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Police Officer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Wm. Hipsley

14. BIRTHPLACE (city or town) (State or country) Howard Ct.

MOTHER

15. MAIDEN NAME Margaret Lanehart

16. BIRTHPLACE (city or town) (State or country) Balto. Md.

17. INFORMANT Mrs. M. Hipsley

(Address) 2222 W. Fayette St.

18. BURIAL, CREMATION, OR REMOVAL

Place Loudon Park Date Mar. 2, 1944

19. UNDERTAKER Fred. A. Krause & Son

(Address) 1216 S. Charles St.

20. FILED MAR 2 — 1944, 19... Huntington Hill Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 2/28, 1944

22. I HEREBY CERTIFY, That I attended deceased from 2/22, 1944 to 2/28, 1944

I last saw him alive on 2/28, 1944. Death is said to have occurred on the date stated above, at 2:25 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cyst Kidney; Type undetermined	2/22/44
Myocardial Degeneration.	2/26/44

Other contributory causes of importance:

Nephritis Chronic	?

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) Edward G. Bogorad M. D.

(Address) 905 W. Baltimore St.

INFORMATION should be entirely supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

4650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G 14650
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH: Church Home Hospital
(a) Baltimore City, Maryland
(b) Street address Fairmount & Broadway
(c) Hospital or institution: C.H.H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 E. 36th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gibson, Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Separated (Married)

6 (b) Name of husband or wife Joseph W. Gibson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 57 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charlie Stewart
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Simmons
15. Birthplace Baltimore

16 (a) Informant Mrs. Geo. [illegible]
(b) Address 1300 E. 36th Street

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-4-1944 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Park
Location —

18 (a) Funeral director Mary M. Kindel
(b) Address 40 E. 22nd St.

19 (a) Filed on 1944 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29, 1944, at 9:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10, 1944, to Feb. 29, 1944, and that I last saw her alive on Feb 29, 1944.

Immediate cause of death Shock

Due to Hemorrhage

Due to Carcinoma of cervix
2 vesicovaginal fistula

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible]

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Steven Hatch M. D.
Address C.H.H. Date signed 3-1-44

VS 150

14651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 14651 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Pfieffer

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 6 9

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHNS HOPKINS MEDICAL SCHOOL MAR 1 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAR 2 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10-1944, at 9 57 AM

21. I certify that I took charge of the remains described above, held an Inspection + Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Nelson M.D.
Medical Examiner.

Date signed 2-10-44

10-61

14652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G 14652
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 152 Colvin St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 152 Colvin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gabe Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/21/77

8. AGE: Years | Months | Days | If less than one day hr. 2 min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Unk
13. Birthplace

MOTHER
14. Maiden Name Lillian Johnson
15. Birthplace Unk

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 2 1944 (Date rec'd by registrar) (b) Acting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21 1944, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia Neonatorum

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 2/21/44

0.62

14653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14653
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 S. Fulton Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Laird

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 2 1944 (Date rec'd by registrar) (b) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-44 19 , at 11:00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15-44 19 , to 1-22-44 19 , and that I last saw h[illegible] alive on 1-22-44 19 .

Immediate cause of death Generalized Arterio-Sclerosis — Duration

Due to

Due to

Other Conditions Simple Senile Degeneration
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas R. Lusby M.D.
Address Franklin Sq. Hosp. Date signed 1/23/44

VS 8

0.60

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14654

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 92B

G 14654
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Neshaminy (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 N Almond Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Truza

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1915

8. AGE: Years	Months	Days	If less than one day
28	7	—	hr. min.

9. Birthplace Neshaminy, Penna (Town, county, and state)

10. Usual Occupation Clerical Supervisor

11. Industry or business

FATHER
12. Name George Truza
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Ella Lapos
15. Birthplace Czechoslovakia

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 6 (day) 44 (year)
(c) Cemetery or crematory Catholic Cemetery
Location Neshaminy Pa

18 (a) Funeral director STEWART & MOWEN COMPANY (W. F. WOODEN SUC.)
(b) Address 108 W. NORTH AVENUE

19 (a) MAR 8 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1944 to Mar. 2 1944, and that I last saw her alive on Mar. 2 1944

Immediate cause of death	Duration
Mitral stenosis	?
Due to Thrombosis of left femoral vein	1 day
Due to	
Other Conditions Schizophrenia Catatonic type	1 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald F. Hayes M. D.
Address 236 Tarleton Rd Date signed

VS 3

G 14655

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14655 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 21½ St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E. 21½ St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MAZZIE HOPKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1907

8. AGE: Years 37 | Months 1 | Days - | Under 1 day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Frank Hopkins
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelina Anderson
15. Birthplace Maryland

16 (a) Informant Laura Mickens
(b) Address 333 E 21½ St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto

18 (a) Funeral director Rayner Sanders
(b) Address 1544 E. Preston St

19 (a) (b) Funeral Director Williams, Md.

MAR 2 1944
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1944 at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1944 to 2/28 1944 and that I last saw her alive on 3 PM 1944.

Immediate cause of death 2/28 Respiratory Failure — Duration Minutes

Due to Pulmonary Tuberculosis — For Months

Due to — For Years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. R. Julian, M.D.
Address 434 E. 23rd St. Date signed 3/1/44

VS 150

For Dr Robt Lee Graham, by Thomas J. Mackin, M.D.

449313

14656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

G 14656

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Bethel St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Carrie Wylie

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex Female

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5-1-91

8. AGE: Years 46 | Months 9 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace S. C (Town, county, and state)

10. Usual Occupation None

11. Industry or business .....

FATHER
12. Name Jim Wylie
13. Birthplace S.C.

MOTHER
14. Maiden Name Lannie ?
15. Birthplace S C

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-44 (month) (day) (year)
(c) Cemetery or crematory Shipped
Location Black Stock S. C

18 (a) Funeral director Rayner Sanders
(b) Address 1424 E. Preston St

19 MAR 2 1944 (Date rec'd by registrar) (b) Registrar's No. .....

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1944 at 8 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 19 44 to Feb 29 19 44 and that I last saw her alive on Feb 29 19 44

Immediate cause of death Pneumonia
Portsmouth, P.O.
Due to gastric ulcer perforation
Due to Luetic syphilis of stomach
Other Conditions .....
(Include pregnancy within 3 months of death)

Duration

Date of operation 2/21/44
Major findings of operation Luetic syphilis of stomach
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature J. H. Slone
Address J. H. H. Date signed 3/1/44

VS 150

G 14657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

G 14657 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pearl Lee Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1902

8. AGE: Years 41 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Shores Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Tyle Brown

13. Birthplace Va

MOTHER 14. Maiden Name Bell Washington

15. Birthplace Va

16 (a) Informant Helen Harris

(b) Address 201 Madison St Buffalo N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 2 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location

18 (a) Funeral director Mrs Kate R. Williams

(b) Address 222 N. Edmondson St.

MAR 2 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1944 at 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1944 to Feb 28 1944 and that I last saw h[illegible] alive on Feb 28 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 6 days

Due to Essential Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature G. H. Barnard M. D.

Address Provident Hospital Date signed 2-28-44

VS 150

G 14658

VA-86337

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92E

G 14658
Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Vanover

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-8382

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
50 ?			hr. min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation Laundry work

11. Industry or business UP-to-Date Laundry

FATHER
12. Name John Vanover
13. Birthplace Ga.

MOTHER
14. Maiden Name Mary Peavy
15. Birthplace Ga.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 2 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1944, at 6:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5/44 19 to 2/28 1944, and that I last saw him alive on 2/28 19 44.

Immediate cause of death Endocarditis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl R. Kinney M. D.
Address B. C. H. Date signed 3/1/44

BG 14659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G 14659

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Gunnridge road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Roy Clinton Brinton

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1898

8. AGE: Years 45 | Months 4 5 | Days 5 6 | If less than one day — hr. — min

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Florist

11. Industry or business

FATHER
12. Name Mr Benjamin F. Brinton
13. Birthplace Delaware

MOTHER
14. Maiden Name Della Tait
15. Birthplace Delaware

16 (a) Informant Mrs Nancy Brinton
(b) Address 100 Gunnridge Road Towson

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/2/44 (month) (day) (year)
(c) Cemetery or crematory Marshall Yeatman & Son
Location Wilmington, Delaware

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland

19 (a) Date received MAR 2 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944, at 7 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1944, to March 1 1944, and that I last saw him alive on March 1 1944.

Immediate cause of death Respiratory - Cardiac failure

Due to Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James N. McCosh M. D.
Address Union Memorial Hospital Date signed 3-1-44

G 14660

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92D

Registered No. G 14660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Jan.31, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since Jan.31, 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 143 11th St., S.E. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME VERNON PALMER DODSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rose Lee Worrell
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1907

8. AGE: Years	Months	Days	If less than one day
36	5	8 9	hr. min.

9. Birthplace Burke, Va. (Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Merchant Seaman

FATHER
12. Name Ellis Dodson
13. Birthplace Burke, Va.

MOTHER
14. Maiden Name Lena Stimpson
15. Birthplace Loudon Co., Va.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/2/44 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director W. H. Chambers
(b) Address Washington, D.C.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 2 1944

VS 10C

MEDICAL CERTIFICATION A.

20. DATE OF DEATH March 1, 1944, at 11:42 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan.31, 1944 to Mar. 1, 1944, and that I last saw him alive on Mar. 1, 1944.

Immediate cause of death Acute & Chronic Ulcerative Colitis — Duration Unk.

Due to

Due to

Other Conditions Myocardial degeneration and fibrosis from old coronary insufficiency. (Include pregnancy within 3 months of death) — Unk.

Date of operation 2/5/44-Proctoscopy; 2/26/44-Ileostomy. Major findings of operation: Ulcerative colitis

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [signature]
Address Baltimore, Md. Date signed 3/1/44 M. D.

MS-50743

C 14661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125R

C 14661 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 555 Bloom (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME Tollie FAX

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	BLACK	MARRIED

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 26, 1876

8. AGE: Years	Months	Days	If less than one day
68	-1	-3	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER

12. Name George FAX

13. Birthplace Md

MOTHER

14. Maiden Name Alice Ross

15. Birthplace Md

16 (a) Informant Nellie Fax

(b) Address 555 Bloom St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/44 (Month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem. Pk.

Location Baltimore Co. Md

18 (a) Funeral director Mrs. George W. Holland

(b) Address 1651 Druid Hill Ave.

MAR 2 - 1944 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1944 at 5:02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1944 to Feb 29 1944 and that I last saw h[illegible] alive on Feb 29 1944.

Immediate cause of death: Respiratory Failure

Due to Cortical atherosclerosis ? infection

Due to ? Weil's disease ? Cerebral thrombosis

Other Conditions Unknown disease C

(Include pregnancy within 3 months of death)

Date of operation Septicemia and jaundice

Major findings of operation:

of autopsy: not reported

Duration
6 days
6 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John R. Birmingham M. D.

JNH

Address Date signed 2-29

In Cabinet
13-G 14662

G 14662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 Alpine Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 Alpine Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances B. De Moss.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife Arthur O. De Moss.
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 31, 1873

8. AGE: Years	Months	Days	If less than one day
70	11	—	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Brown
13. Birthplace Maryland.

MOTHER
14. Maiden Name Eleanor Brumbaugh
15. Birthplace Maryland.

16 (a) Informant Arthur O. De Moss.
(b) Address 219 Alpine Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road.

18 (a) Funeral director Thomas F. Donovan
(b) Address 316-17 Chestnut Ave
(c) MAR 2 - 1944 (b)
(Date rec'd by registrar)

VS 250

Huntington Publishing Co.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1944 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25th 1944, to March 1st 1944, and that I last saw h e alive on March 1st 1944.

Immediate cause of death Influenza & Broncho Pneumonia — Duration 4 days

Due to Carcinoma of Breast Metastasis — Duration long

Due to

Other Conditions Ca

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 221 N Calvert St Date signed March 4, 1944 M. D.

G 14663

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G 14663 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Bon~~ Fayette & Paca Sts
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Valley View Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Ella May Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Alpheus F. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1871

8. AGE: Years	Months	Days	If less than one day
72	9	12	hr. min

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John T. Gimnavan
13. Birthplace Md

MOTHER
14. Maiden Name Ellen Biggs
15. Birthplace Easton Shore, Md

16 (a) Informant Alpheus F. Williams
(b) Address 4301 Valley View Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) MAR 2 - 1944 (Date rec'd by registrar) (b) Hunting for Williams M.P. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1944, at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1944, to 3/2 1944 and that I last saw her alive on 3/1 1944.

Immediate cause of death Uremia — Duration 6 days
with some Alb. Nephritis

Due to Nephritis - Arteriosclerotic

Due to Bronchopneumonia

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Chas. Norton, Jr. M. D.
Address Bon Secours Hospital Date signed 3/4/44

VS 3

J. CHAS. NORTON

G 14664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G 14664 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4317 Mainfield Ave.
(c) Hospital or institution: Church Home + Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4317 Mainfield Ave. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lottie Shirley

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Charles C. Shirley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1876

8. AGE: Years	Months	Days	If less than one day
67 yrs	7	26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Arnold
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura J. Cyle
15. Birthplace Maryland

16 (a) Informant Husband
(b) Address 4317 Mainfield Ave, Balto.

17 (a) Removal Burial (Burial, cremation, or removal) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory Baker Cemetery
Location Aberdeen, Maryland

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Harford Road

MAR 2 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1/44 19 . at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20, 19 44, to March 1, 19 44, and that I last saw h[er] alive on March 1 19 44.

Immediate cause of death Pulmonary Edema

Due to Cardiac failure - rheumatic heart disease 12 bact. endocarditis

Due to Acute hemorrhagic nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Marked thrombosis, rheumatic heart disease

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Steven Haith M. D.
Address C.H.H. Date signed 3-2-44

G 14665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14665 / 117a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~515 Albemarle~~

(c) Hospital or institution: JOHNS HOPKINS HOSP.

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 515 Albemarle St (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Thomas De Chiaro (DeCesare)

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	218-10-1426	Male	White	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 11 1897

8. AGE: Years	Months	Days	If less than one day
46 ~~yrs~~	6	18	50 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business .....

FATHER	12. Name Phillip Duchess
	13. Birthplace Italy
MOTHER	14. Maiden Name Belinda Liboria
	15. Birthplace Italy

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSP.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof March 4/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose

(b) Address 52 N. Morley St.

MAR 2 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944 at 8-20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1944 to Mar 1 1944 and that I last saw h~~e~~ alive on Mar 1 1944

Immediate cause of death ~~Peritonitis~~ Shock

Due to Peritonitis

Due to Perforated Peptic Ulcer

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation 2-24-44

Major findings of operation: Perforated Gastric Ulcer

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature George Burch M. D.

Address Johns Hopkins Hosp. Date signed 3-1-44

G 14666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 61

G 14666 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 Callow Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (if outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Callow Ave (if rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Silberman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
71 70			hr min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Sidney Goldstein
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Louis Silberman
(b) Address 2408 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) Date received (b) (Registrar) Registered

MAR 2 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1944 at 8,45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1944 to 3/2 1944, and that I last saw h[er] alive on 3/[illegible] 1944.

Immediate cause of death Acute Coronary infarction — Duration

Due to Coronary Sclerosis

Due to Ch. Hypertention

Other Conditions Ch Diabetes

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Arcquith St Date signed 3/2/44

14667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14667
Registered No.

1612

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville - 28 - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Hilltop Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-1-44

8. AGE: Years | Months | Days | If less than one day: 7 hrs 10 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name George Samuel Tyler
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Thelma Jane Russell
15. Birthplace Baltimore Md.

16 (a) Informant George Tyler
(b) Address 609 Hilltop Rd Catonsville

17 (a) Burial (b) Date thereof 3/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 2 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1-1944, at 11.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1944 to 3-1 1944, and that I last saw h[illegible] alive on 3-1 1944.

Immediate cause of death — Duration

Massive Collapse of Lung.
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alton H Counselman
Address 1204 Druid Ave Date signed 3/3/44
M. D.

VS 3

C 14668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G 14668 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 E. Lorraine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Bonsal

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2.

8. AGE: Years	Months	Days	If less than one day
about 97			hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name (Unknown) Bonsal
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Walter J. Harrison
(b) Address 3026 Abell Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/5 — (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Johns
Location Waverly

18 (a) Funeral director H. M. Cook Inc
(b) Address 215 St. Paul St

19 (a) MAR 3 - 1944 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1/44 19 . at 9:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Charles J. Latrimer M.D. Medical Examiner.
Date signed 3/4/44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14669

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 14669

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town DUNDALK (If outside city or town limits, write RURAL and give town)
(d) Street No. 7718 Norbush Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Charles, Dieter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife: Hedwig Louise Dieter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-6-83

8. AGE: Years	Months	Days	If less than one day
60	2	26	hr. min.

9. Birthplace PENNA (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Smith J. Dieter
13. Birthplace PENN

MOTHER
14. Maiden Name Louise King
15. Birthplace VA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave - Extended

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 3 - 1944 (Date rec'd by local reg.) (b) Huntington Williams Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 2 1944, at 1:58 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 1 1944 to MAR 2 1944, and that I last saw h/M alive on MAR 2 1944.

Immediate cause of death: Lobar pneumonia RML, RLL, L.LL — Duration
Due to: pneumococcus type 3
Due to:
Other Conditions: Leukemia, lymphogenous, chronic
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place) While at work) (Specify type of place)
(e) Means of injury

23. Signature John R. Bermingham
Address JHH Date signed 3-2

14670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 14670 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Barrison Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes May Goodwin

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ David R. Goodwin deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1863

8. AGE: Years	Months	Days	If less than one day
80	7	1	hr. min.

9. Birthplace Brooklyn, N. Y. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Cyrus Hibbard
13. Birthplace Wisconsin

MOTHER
14. Maiden Name Fales
15. Birthplace Brooklyn, N Y.

16 (a) Informant Miss Hope Goodwin
(b) Address 1449 Homestead

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-5-44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenwood
Location New York N. Y.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 3 - 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2- 1944, at 3 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to hers death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardio - respiratory failure

Due to Pneumonia

Other Conditions Fractured left hip.
Acute Paralytic
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 2-20-44 at P. M.
(b) Where did injury occur? 2910 Barrison Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Nursing Home While at work? no
(d) Means of injury Fell on bed-room floor

23. Signature Howard Clendenin M.D.
Medical Examiner.
Date signed 3-2-44

G 14671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14671 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1425 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin A. Brandt,

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-9101

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna E. Brandt.
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) March 17. 1871

8. AGE: Years 72 | Months 11 | Days 12 | If less than one day: hr min

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Brandt Corp.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Anna E. Brandt.
(b) Address 1425 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3. 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director Robert S. Little,
(b) Address 2700 Edmondson Ave.

19 MAR 2 - 1944 (Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 29 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 19 44 to Feb 29 19 44 and that I last saw him alive on Feb 29 19 44

Immediate cause of death Lobar pneumonia — Duration 3 days

Due to

Due to

Other Conditions Chronic Cardio vascular dis

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest W. Kahn
Address 1735 Pops Gr Ext Date signed 3/1/44

PHYSICIAN

Underline the cause to which death should be charged statistically

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

449923

14672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

14

G 14672
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2603 Rosalind Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Diane Robin Stover
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-29-38

8. AGE: Years 5 | Months 10 | Days - | If less than one day: hr min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Hubert Stover
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Md

16 (a) Informant Records
(b) Address [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Orford & Taylor Ave

18 (a) Funeral director Harry E. Wilkes
(b) Address 1101 E Edmondson Ave

MAR 3 1944
19 (a) (Date rec'd by registrar) (b) Huntington Ave Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1944 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1944 to Feb 29 1944 and that I last saw her alive on Feb 29 1944

Immediate cause of death: respiratory failure — Duration

Due to: tuberculous meningitis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Kaye M.D.
Address J H H Date signed 3/2/44

G 14673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14673 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
a State Md b County Balto
c City or town Arlington (If outside city or town limits, write RURAL and give town)
d Street No. 2434 Calverton Rd Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mrs Clara Mueller (Mueller.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Wd M

6 (b) Name of husband or wife Fate three | 6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr

8. AGE: Years 59 | Months | Days | If less than one day hr min

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hets

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Frederick Mueller (Mueller) son
(b) Address 408 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-44 (month, day, year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd.

18 (a) Funeral director Harry A. Wilhelm
(b) Address 711 E Edmondson Ave.

19 (a) MAR 2 1944 (b) (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1944, at 7.55 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19, and that I last saw h OR alive on 2/29 1944

Immediate cause of death
Peritonitis — Duration

Due to Intussuception and

Due to Volvulus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/28/44

Major findings of operation: Intussuception & Volvulus

If autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature F. L. Raffucci - Arlington Md. M. D.

Address Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically

Certificate
G 14674
G ME 6a

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14674 ✓ 186a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Baltimore Gen Hospital 1E-C
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Woodlawn
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 6741 Windsor Mill rd. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) **FULL NAME** Elizabeth Ruler ~~Elizabeth L. Euler~~

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	widowed

6 (b) Name of husband or wife William G. Euler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 14, 1858 Jan 14 1858

8. AGE: Years	Months	Days	If less than one day
86	1	~~14~~ 17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Younger
13. Birthplace United States

MOTHER
14. Maiden Name Catherine Kummerer
15. Birthplace United States

16 (a) Informant Mr. George Euler
(b) Address Dogwood Road., Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 3 - 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Ingallstone, Md.

18 (a) Funeral director E. W. Lamoreau.
(b) Address 4510 Liberty Heights Ave.

MAR 2 - 1944 (Date rec'd by registrar) (b) Interring ~~for~~ Williams ~~M.D.~~ (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944 at 10 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1944, to 3-1 1944, and that I last saw h alive on 3-1 1944.

Immediate cause of death — **Duration**

arteriosclerosis, cerebral hemorrhage

Due to

Due to

Other Conditions
fracture of neck of femur
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Acc.
(b) Date of occurrence 2-12-43 at M
(c) Where did injury occur? 6743 Windsor Mill Rd (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home (Specify type of place) While at work? no
(e) Means of injury slipped, fell & broke hip

23. Signature P. N. Friedman, M.D.
Address West Balt Gen Hosp Date signed 3/3/44

For J. H. L. Mollenweber by Howard L. Russell, M.D.

14675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G 14675
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 S Chester St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore
(If outside city or town limits, write RURAL and give town)
d Street No. 208 S Chester St
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Stanislaus Wisniewski Wiesner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Antonina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired Merchant
11. Industry or business

FATHER
12. Name Peter Wisniewski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Langowski
15. Birthplace Poland

16 (a) Informant Mary Pasek
(b) Address 208 S Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 MAR 3 - 1944 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1944 to Feb. 29 1944 and that I last saw h(I)m alive on Feb 29 1944

Immediate cause of death: ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — Duration: 1943

Due to

Due to GENERALIZED VASCULAR SCLEROSIS — Duration: ??

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, place)
(e) Means of injury

23. Signature Joseph F. Deanga, M. D.
Address 209 S. Chester St Date signed 3/1/44

G 14676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 R

Registered No. G 14676

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Elmley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Elmley Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT EDWARD RHOADS, SR.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-03-6948

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florence Woodall

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1895

8. AGE: Years 49 yrs. | Months | Days 6 | If less than one day: hr. ____ min. ____

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Maintenance Man

11. Industry or business City of Balto.

FATHER
12. Name George W. Rhoads
13. Birthplace Pa.

MOTHER
14. Maiden Name Elmira Stees
15. Birthplace Pa.

16 (a) Informant Wife
(b) Address 3308 Elmley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/44 (month) (day) (year)
(c) Cemetery or ~~Crem~~ Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

MAR 3 - 1944 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1944, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 ____ to 2/29 1944, and that I last saw him alive on Feb. 29 1944

Immediate cause of death: Cirrhosis of liver — Duration: Dec. 23, 1943

Due to ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert M. Wilkerson

Address 1800 N. Charles St. Date signed 3/1/44 (M D)

14677
70 #84078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 12 B

G 14677
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1 3 mos 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) **2 yrs.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Md.** (b) County
(c) City or town **Baltimore** (If outside city or town limits, write RURAL and give town)
(d) Street No. **133 Aisquith Street** (If rural give location)
(e) Citizen of foreign country? **No** (Yes or No) If yes, name country

3 (a) FULL NAME **Anna Bell Hansley**

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	**Colored**	**Single**

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Sept. 25, 1922**

8. AGE: Years	Months	Days	If less than one day
21	**5**	**3**	hr min

9. Birthplace **North Carolina** (Town, county, and state)
10. Usual Occupation **None**
11. Industry or business

FATHER
12. Name **Francis Hansley**
13. Birthplace **North Carolina**

MOTHER
14. Maiden Name **Mary Fennell**
15. Birthplace **North Carolina**

16 (a) Informant **Records, Baltimore City Hosp.**
(b) Address **4940 Eastern Avenue**

17 (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **March 3-1944** (month) (day) (year)
(c) Cemetery or crematory **Burgaw, North Carolina**
Location

18 (a) Funeral director **Robert E. Williams**
(b) Address **1515 M^t Elderry St**

19 **MAR 3 - 1944** (Date filed by Registrar) **Huntington Williams, M.D.** Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH **February 28,** 1944 at **12:20** P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 26 1943 to 2/28 1944, and that I last saw her alive on 2/28 1944.

Immediate cause of death **Pulmonary TBC.** — Duration **2/28/44**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **As above**

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature **Paul Hall**

Address **B.C.H.** Date signed **2/28/44** M D

14678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14678

Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Carney (If outside city or town limits, write RURAL and give town)
(d) Street No. 9413 Harford Rd. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Matilda Russell

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-1589

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John C. Russell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 19th 1882
8. AGE: Years 61 Months 5 Days 13 If less than one day hr. min.
9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation Cafeteria (Waitress)
11. Industry or business Cafeteria (Bendix Corp)
MOTHER / FATHER
12. Name Kenneth Billingsley
13. Birthplace Balto. Co. Maryland
MOTHER
14. Maiden Name Ida Baker
15. Birthplace Balto. Co. Md.
16 (a) Informant Mr. J. C. Russell
(b) Address 9413 Harford Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/44 (month) (day) (year)
(c) Cemetery or crematory Wash. Chapel Location Glen Arbr. Md.
18 (a) Funeral director Sassaman Funeral Home
(b) Address 7401 Belair Road
19 (a) MAR 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/44 19 , at 5 50 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1-25-44 19 , to 3/2/44 19 , and that I last saw h Er alive on 3/2/44 19 .

Immediate cause of death: Cerebral Hemmorhage — Duration: 2 days
Due to: Arterio-Sclerosis
Due to:
Other Conditions: 1) Fracture of Neck of Femur 3½ weeks
2) Broncho-Pneumonia (Lungs) 2 days
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN'S — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Jan 25 1944
(c) Where did injury occur? Bendix Camp (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Industrial Plant (Specify type of place) While at work? Yes
(e) Means of injury Dropped & fell to floor

23. Signature Justin Steele M. D.
Address Franklin Square Hosp. Date signed 3/2/44

VS 1

For Robt. Lee Bonham by Howard J. Masseis, M.D.

G 14679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 14679 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1176 Sargeant St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1176 Sargeant St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wallace S. Thompson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1943

8. AGE: Years | Months: 9 | Days: 11 12 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Charles Thompson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alverda Chaillou
15. Birthplace Baltimore, Md.

16 (a) Informant Mr Charles Thompson
(b) Address 1176 Sargeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Hedgett Road

18 (a) Funeral director John F Cowan Son
(b) Address 9603 Baltimore St

19 MAR 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to March 2 1944, and that I last saw h alive on March 1 1944.

Immediate cause of death: Bronchopneumonia — Duration: 10 da.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Dana Moore M. D.
Address 3105 Belair Rd Date signed 3-2-44

G 14680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G 14680

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 Dolphin St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Dolphin St
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Florence Lee Stodges Kettler

3 (b) If veteran, name war no

3 (c) Social Security Account No. none

4. Sex Female **5. Color or race** White **6 (a) Single, married, widowed, or divorced** Married

6 (b) Name of husband or wife Wm. H. Kettler

6 (c) If alive, give ~~84~~ 86 years

7. Birth date of deceased (mo., day, yr.) Dec-28-1871

8. AGE: Years 72 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Kenzie Johns Stodges
13. Birthplace Balto Md

MOTHER
14. Maiden Name Louisa Allen
15. Birthplace Balto Md

16 (a) Informant Mrs Hazle M. West (Daughter)
(b) Address 4435 Kirkpatrick Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3-4-44 (month) (day) (year)
(c) Cemetery or crematory Greenmt
Location Baltimore City

18 (a) Funeral director Steward Mortuary Co.
(b) Address 108 W Lexington St.

19 (a) (Local registrar) **(b)** Hattie [illegible] Registrar

MAR 7 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1943 to March 1 1944 and that I last saw h[illegible] alive on March 1 1944

Immediate cause of death	Duration
Coronary Occlusion	2 days
Due to Coronary Sclerosis	1 year
Due to	
Other Conditions Serious Carcinoma of Lung (Include pregnancy within 3 months of death)	1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 716 Cathedral St. Date signed 3-7-44 M. D.

G 14681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

G 14681 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 N. Washington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 630, N. WASHINGTON ST
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Franke.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: no

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna G. Franke.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4th, 1878

8. AGE: Years 65 | Months 3 6 | Days 2 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Conductor

11. Industry or business P.R.R.

FATHER
12. Name William J. Franke.
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown,

16 (a) Informant Anna G. Franke.
(b) Address 630. N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 5th 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer St.
Location Belair Rd.

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N. Wolfe. St

MAR 3 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1938, to March 2 1944, and that I last saw h alive on 19

Immediate cause of death: Chron. Cor Pulmonale

Duration: 5yrs.

Due to: Chron-Asthmatic Bronchitis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J. Ayd M. D.
Address 3005 E. Monument St Date signed 3/3/44

VS 8

G 14682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14682
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 850 Whitmore Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 850 Whitmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Russell

3 (b) If veteran, name war --

3 (c) Social Security Account No. 705-05-3542

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Julia Russell
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr) Nov 23, 1871

8. AGE: Years 72 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Pensioned - B. & O.

11. Industry or business Railroad (B. & O.)

FATHER
12. Name Charles Russell
13. Birthplace Austria

MOTHER
14. Maiden Name Barbara Chamrad
15. Birthplace Austria

16 (a) Informant Julia Russell
(b) Address 850 Whitmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 9 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1944, at 6 05 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Thrombosis

Due to Arteriosclerotic Cardiovascular

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/[illegible]/44

G 14683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G 14683 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 N. Ellamont St.
(c) Hospital or institution:

16-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 N. Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SUSAN GIFFORD LEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1859

8. AGE: Years	Months	Days	If less than one day
84	5	4	hr. min.

9. Birthplace Cecil Co., Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Benjamin Gifford
13. Birthplace Bucks Co., Pa.

MOTHER
14. Maiden Name Susan Watson
15. Birthplace N. J.

16 (a) Informant Mrs. Edna Smith
(b) Address 1630 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory Rosebank Cem.
Location Cecil Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 3 - 1944 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1944, at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to March 2 1944 and that I last saw h-r alive on March 2 1944.

Immediate cause of death Myocarditis — Duration about 1 yr. — 9

Due to arterio sclerosis — 1 yr.

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles S. Abbott M. D.
Address 22 20 Garrison Date signed March 2 44

G 14684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

G 14684
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 S. Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 S. Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Joseph Reilly
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25 1944

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward J. Reilly
13. Birthplace Ft. Catalina

MOTHER
14. Maiden Name Lillian Nawahanusha
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Edward J. Reilly
(b) Address 121 S. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) MAR 2 - 1944 (Date received by registrar) Hunting on [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944 at 5 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1944 to Mar 2 1944 and that I last saw him alive on Mar 2-1944

Immediate cause of death

Due to Congenital Heart

Due to Mongolian Idiocy

Other Conditions

(Include pregnancy within 3 months of death)

Duration: 8 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D. (Date signed)

G 14685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G 14685
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2221 Canary Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Kelch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife George W. Kelch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30-1887

8. AGE: Years 56 | Months 6 | Days 1 | If less than one day: hr. min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Phillip A. Bernhardt
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eliza. Davis
15. Birthplace Balto. Md.

16 (a) Informant George W. Kelch
(b) Address 305 S. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location O'Donnell St.

18 (a) Funeral director John R. Miller
(b) Address 265 Jefferson St, Washington Village

19 (a) MAR 3 - 1944 (Date received by registrar) (b)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 1st 1944 at 2p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1944 to Mar 1st 1944, and that I last saw h alive on Feb 27 1944.

Immediate cause of death: Malignant Cachexia — Duration: Several months

Due to: Malignancy of Ovaries & Stomach — 8 mos

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. F. Rice M. D.

Address 24 S. Broadway Date signed Mar 3/44

G 14686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G 14686 Registered No. 2698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1033 Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 Stricker St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles Henry Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	Widower

6 (b) Name of husband or wife Mrs. Rosa Williams
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 15, 1878

8. AGE: Years	Months	Days	If less than one day
65	11	16	hr. min.

9. Birthplace Prince George Co. Md (Town, county, and state)
10. Usual Occupation Car Washer
11. Industry or business car washers

FATHER
12. Name Thomas Williams
13. Birthplace maryland

MOTHER
14. Maiden Name unknown
15. Birthplace maryland

16 (a) Informant Pearl Marie Brooks
(b) Address 932 Stricker St.

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory St Peter
Location Md

18 (a) Funeral director Geo. G. Kelsay
(b) Address 1303 Preastman St

19 MAR 3 — 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 — 1 — 1944, at 7:P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 — 1 — 1943 to 3 — 1 — 1944, and that I last saw him alive on 3 — 1 — 1944.

Immediate cause of death Nephritis — Duration Long time

Due to

Due to

Other Conditions Bronchitis & Myocarditis — 4 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 3-2-44

G 14687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 14687 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bethlehem - Fairfield Conf.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 Myrtle ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie P. Dorsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife Lucy

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1900

8. AGE: Years	Months	Days	If less than one day
43	4	6	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Defense Worker
11. Industry or business

FATHER
12. Name C. Marcellus Dorsey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary —
15. Birthplace Balto. Md.

16 (a) Informant Lucy C. Dorsey
(b) Address 1423 Myrtle Ave

17 (a) Burial (b) Date thereof 3/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Md

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Pleasant St

19 (a) MAR 3 - 1944 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1- 1944, at 11 P. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulsein M.D.
Medical Examiner.
Date signed 3-2-44

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14688

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14688 Registered No. 92 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 Pontiac Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 Pontiac Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha E. Amend.

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Christian L.

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 13, 1892

8. AGE: Years 51 | Months 7 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation At Home.
11. Industry or business

FATHER 12. Name Thomas Mailey
13. Birthplace Balto.

MOTHER 14. Maiden Name Mary Jane Rutherdale
15. Birthplace Balto

16 (a) Informant Christian Amend.
(b) Address 827 Pontiac Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Road

18 (a) Funeral director M. W. L. Dippel's Sons
(b) Address Lombard & Ann Sts.

19 (a) ..... (b) .....
(Date rec'd by registrar) MAR 3 - 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1944 to March 1944. and that I last saw her alive on March 1944.

Immediate cause of death: acute dilatation of heart — Duration: 2 days
Due to: Mitral regurgitation — Duration: 9 mos
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell
Address Mary Hanna Date signed 3/5/44

14689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94B

G 14689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 E. Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 E. Monument. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Marie Vaeth.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jerome E. Vaeth | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/19/1895

8. AGE: Years 48 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Stenographer
11. Industry or business Oneill & Co

FATHER
12. Name A. J. Jaeckisch
13. Birthplace Berlin - Md.

MOTHER
14. Maiden Name Dorthea M. Bosse
15. Birthplace Baltimore

16 (a) Informant Miss Jaeckisch
(b) Address 2916 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location J. J. Fahey & Sons.

18 (a) Funeral director
(b) Address 1318 Light St.

MAR 3 - 1944 Registered by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1943 to March 2 1944, and that I last saw her alive on March 1 1944.

Immediate cause of death: Angina pectoris — Duration: 5 months
Due to
Due to
Other Conditions Hypertension. — 5 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. J. Schmitz
Address 701 N. Howard St. Date signed 3/2/44 M. D.

VS 8

14690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

V

G 14690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 S. Bond St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Abraham Thomas.

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Hester —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1879

8. AGE: Years 65 | Months — | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, or state)

10. Usual Occupation Janitor (Unemployed)

11. Industry or business

FATHER 12. Name David Thomas

13. Birthplace Md.

MOTHER 14. Maiden Name Cassandra Johnson

15. Birthplace Md.

16 (a) Informant Bertha Nash (Sister)
(b) Address 1506 E. Madison St.

17 (a) Burial (b) Date thereof 3-4-44 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Robert L. Young
(b) Address 804 N. Carrollton Ave.

MAR 3 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1944 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15, 1943 to Feb. 29, 1944, and that I last saw h/m alive on Feb. 29, 1944.

Immediate cause of death: Hypertensive Cardiovascular Renal Disease

Duration: 1 yr

Due to

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Adams M. D.
Address 312 E 23rd St. Date signed 3-1-44

VS 3

G 14691
AB-29035

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
61

G 14691
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 1346
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~6 yrs 2 mos~~ 27days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Conduit Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1874

8. AGE: Years	Months	Days	If less than one day
69?	6	1	hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Mt. Vernon Woodberry

FATHER
12. Name xx John T. Parks
13. Birthplace x Maryland

MOTHER
14. Maiden Name xx ---
15. Birthplace ?

16 (a) Informant Charles W. Parks
(b) Address 3528 Clipper Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3611 Falls Rd.

19 (a) Filed MAR 6 1944 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1 1944, at 7.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1937, to 3-1 1944, and that I last saw h[illegible] alive on 3-1 1944.

Immediate cause of death

Cirrhosis of Liver

Due to Diabetes Mellitus

Due to Gen. Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-18-44

Major findings of operation: Cirrhosis of Liver

of autopsy:

Duration
3 wks
7 yrs
4 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald B. Lebo M. D.
Address Balto City Hosp Date signed 3-2-44

G 14692

TH. 86628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Elrino St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: John Motyka

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-4937

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Genevieve

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Sept 16th, 1916

8. AGE: Years 27 | Months 5 | Days 26 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Foreman

11. Industry or business: Glen L. Martin

FATHER
12. Name: Joseph Motyka
13. Birthplace: Poland

MOTHER
14. Maiden Name: Catherine Pondo
15. Birthplace: Poland

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Linn Street

MAR 3 - 1944 (Date rec'd by Registrar) Huntington Williams, Hlth Officer

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1944, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944, to 3/2 1944, and that I last saw him alive on 3/2 1944.

Immediate cause of death: Brain Tumor ? — Duration: 1 week

Due to: Idiopathic epilepsy ?

Due to: Hypertension & cerebral accident ?

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hemorrhagic encephalitis

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Earl P. Kinney M. D.

Address B.C.H. Date signed 3/3/44

G 14693 DORRETT ✓ G 14693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3031 Pinewood ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 Pinewood ave (Rooms)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Dorrett

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-07-1405

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife Annie Wantock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/1880

8. AGE: Years 63 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Continental Can Co.

FATHER
12. Name William
13. Birthplace Md.

MOTHER
14. Maiden Name Lucas
15. Birthplace Md.

16 (a) Informant Family
(b) Address 504 Harwood Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location 6 North Ave

18 (a) Funeral director Jerrell McCarty
(b) Address 324 E. Fort Ave

19 (a) 1944 (Date rec'd by registrar) (b) 0 Registrar

MAR 3

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 2 - 1944, at 10 15 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wesdeis M.D.
Medical Examiner.
Date signed 3-2-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14694

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14694

Registered No. 46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Calvert
(c) City or town Prince Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Coates

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Black	married

6 (b) Name of husband or wife Octavia Coates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 50			hr min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farming

11. Industry or business Farming

FATHER
12. Name Ben Coates
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Thomas
15. Birthplace Maryland

16 (a) Informant Nathaniel Coates
(b) Address Owings Mills, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 8 44 (month) (day) (year)
(c) Cemetery or crematory Patapsco
Location Baltimore Co.

18 (a) Funeral director P. E. Lamdin
(b) Address Prince Frederick, Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

MAR 9 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 5:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1944, to March 2 1944, and that I last saw him alive on March 2 1944.

Immediate cause of death Obstruction of small bowel — Duration Several days

Due to Fibrosarcoma of pelvis & generalized fibrosarcomatosis — 7 weeks

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb. 19, 1944.

Major findings of operation: Numerous nodules of fibrosarcoma. Many large tumors. Generalized fibrosarcomatosis. Obstruction of small bowel.

of autopsy —

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Ellsworth Cook

Address Mercy Hospital Date signed 3/3 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

G 14695

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95B

Registered No. G 14695

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayman Ave & Berkeland St
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 N High (If rural give location)
(e) Citizen of foreign country? Sicily (Yes or No) If yes, name country

3 (a) FULL NAME Frank Parinello

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Marie Parinello
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 19 1875

8. AGE: Years	Months	Days	If less than one day
68?	10	13	hr. min.

9. Birthplace Sicily (town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name John Parinello
13. Birthplace Italy

MOTHER
14. Maiden Name Marie Adamo
15. Birthplace Italy

16 (a) Informant Frank Parinello
(b) Address 1544 Oswego Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 7 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director J. V. Lipsinger
(b) Address 3818 E. Baltimore St.

19 (c) MAR 9 1944 (Date rec'd by local registrar) (b) Huntingtor Williams, M.D. (Signature of local registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1943 to 3-2 1944 and that I last saw h[illegible] alive on 3-2 1944.

Immediate cause of death Bacterial Endocarditis — Duration

Due to Rheumatic heart disease

Due to

Other Conditions Congestive Kidney disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Bact. Endocarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lucian Baldwin M.D.
Address West Baltimore General Hospital Date signed 3/5/44

G 14696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14696 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 S Aldhaun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 S Aldhaun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alma a Thoren

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Ferdinand C Thoren
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Dec 3 1886

8. AGE: Years	Months	Days	If less than one day hr.	min.
57	2	29		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Herman Bardsley
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Jenes
15. Birthplace Baltimore

16 (a) Informant Ferdinand C Thoren
(b) Address 500 S Aldhaun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 6th (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans

19 (a) (Date rec'd) (b) Registrar

MAR 3 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944 at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944, to March 2 1944, and that I last saw h[illegible] alive on March 2nd 1944

Immediate cause of death	Duration
Chronic Myocarditis	
Due to also High Blood pressure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Adam a Tod M. D.
Address Dundalk Ave Date signed March 3
Balto md 1126

G 14697

JO #86688

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14697 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 S. Bouldin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Harry Gorge

3 (b) If veteran, name war

3 (c) Social Security Account No. 195-05-0658

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1891

8. AGE: Years 52 | Months 8 | Days 16 | If less than one day: hr min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Unemployed

11. Industry or business

FATHER
12. Name: Paul Gorge
13. Birthplace: Russia

MOTHER
14. Maiden Name: Anna H. Schumacher
15. Birthplace: Baltimore Md.

16 (a) Informant: Louise Gorge
(b) Address: 1117 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel
Location: O'Donnell St.

18 (a) Funeral director: Clarence F. Hoffmann
(b) Address: 1639 N. Broadway

19 (a) (Date rec'd by registrar) MAR 3 - 1944 Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 29, 1944, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 19 44 to 2/29 1944, and that I last saw h alive on 2/29 19 44.

Immediate cause of death: Terminal Lobar Pneumonia, advanced Tuberculosis. — Duration: 2d.

Due to: — Duration: 8 mos.

Due to: Chron. Alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Tuberculosis of lung, small, stained with [illegible]

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E. L. Seigman M. D.

Address: 1314 Date signed 2/29

14698 450100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14698 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 S. Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME L.D. Bright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Lessie
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 12-25-12

8. AGE: Years	Months	Days	If less than one day
31	2	7	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation RAILROAD
11. Industry or business

FATHER
12. Name John Bright
13. Birthplace S.C.

MOTHER
14. Maiden Name Florie Blue
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 3/44 (month) (day) (year)
(c) Cemetery or crematory
Location Durham N. Carolina

18 (a) Funeral director Mrs. Robert A. Elliott & Dyk
(b) Address 1109 N. Carolina Street

19 (a) (b) Huntington Williams
Registered by (Registrar) Registrar

MAR 3 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 2 1944 at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1944 to MAR 2 1944, and that I last saw him alive on MAR 2 1944.

Immediate cause of death Respiratory Failure — Duration

Due to Lobar pneumonia RUL & LL Pneum. Type I & Streptococcus — 2 days

Due to

Other Conditions Arteriosclerosis, Chronic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Graham Venable, Jr.
Address 3. Hopkins Date signed 3-2
M. D.

G 14699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

G 14699

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W 22 St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Rose Jefferson

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	BLACK	MARRIED

6 (b) Name of husband or wife Clifford Eugene

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 2, 1908

8. AGE: Years	Months	Days	If less than one day
35 36	11	29	hr ..... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

MOTHER / FATHER

12. Name William Cazart

13. Birthplace NC

MOTHER

14. Maiden Name Emma Smith

15. Birthplace NC

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4 1944 (month) (day) (year)

(c) Cemetery or crematory Bel. Calvary Cem.

Location Old County Rd.

18 (a) Funeral director Mrs. Robert G. Elliott & Son

(b) Address 1129 N. Carlton St.

19 (a) MAR 3 - 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 1 1944. at 3 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1944. to MAR 1 1944, and that I last saw her alive on MAR 1 1944.

Immediate cause of death	Duration
(a) Irreversible shock	
Due to (b) intestinal obstruct.	
Due to (c) Mechanical obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy Mech. obstruct.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature George Burgess M. D.

Address Johns Hopkins Hosp. Date signed 3-14-44

G 14700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 14700

108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 553 W. Biddle St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 553 W. Biddle St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Camphor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1903

8. AGE: Years 40 | Months 11 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Phillip Camphor

13. Birthplace Md.

MOTHER

14. Maiden Name Sarah Talbert

15. Birthplace Md.

16 (a) Informant Mrs. Mamie Butler

(b) Address 904 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) ... (b) Thurston for Williams, M.D. (Date received by registrar) Registrar

MAR 3 1944

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March 1, 1944, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1944 to Mar 1 1944, and that I last saw h[illegible] alive on [illegible] 1944.

Immediate cause of death — Duration

Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr Frank E. Wagner M. D.

Address 3127 Eastwood Ave. Date signed

G 14701

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 14701 Registered No.

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 GOUGH ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 47 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 GOUGH ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSA FIORUCCI

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife RAYMOND FIORUCCI
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 15 1867

8. AGE: Years	Months	Days	If less than one day
96 77	7	16	hr. min.

9. Birthplace ITALY (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name ANGELO RONCONI
13. Birthplace ITALY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ITALY

16 (a) Informant LOUIS FIORUCCI (SON)
(b) Address 1623 GOUGH ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 4/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) MAR 3 1944 (Date received by registrar) (b) Huntington Williams (Registrar) MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 1 1944, at 9pm. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1943 to March 1 1944 and that I last saw her alive on March 1 1944

Immediate cause of death: Coronary Thrombosis — Duration: 2/28/44

Due to: Chronic Myocarditis — 8/1/43

Due to: Arteriosclerosis — 1940

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Ronconi M.D.
Address 801 Kenwood Ave. Date signed 3/7/44

G 14702

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G 14702 Registered No.

Please write plainly, preferably in ink. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1636 Cole Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Cole Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Dora W. Robinson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Stuart H. Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 24, 1877

8. AGE: Years 66 | Months 4 | Days 18 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ludwig Rauck
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhemina Henaeman
15. Birthplace Germany

16 (a) Informant Stuart H. Robinson
(b) Address 1636 Cole Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director Geo. W. Schwab
(b) Address 2101 Frederick Avenue

19 (a) MAR 3 1944 (Registered) (b) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1943 to March 2 1944, and that I last saw her alive on Mar 2 1944.

Immediate cause of death: Arterio-sclerotic cardio-vascular disease — Duration: 6 mos.
Due to
Due to
Other Conditions: Cerebral thrombosis — Duration: 4 days
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 30 Wilkens ave. Date signed 3/3/44

MAR 3 1944

G 14703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 25

G 14703 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1801 DeSoto Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 + 2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balto., City
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 DeSoto Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Bertha Stiles

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-6-41

8. AGE: Years	Months	Days	If less than one day
2	2	25 26	hr. min.

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Paul W. Stiles
13. Birthplace Baltimore.

MOTHER
14. Maiden Name Bertha L. Bryan
15. Birthplace Virginia.

16 (a) Informant Paul W. Stiles
(b) Address 1801 De Soto Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director C. Raymond Kaufman
(b) Address 1026 Reeds Avenue.

19 (a) (Date received by Registrar) MAR 3 1944 (b) [illegible] for Williams, M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944 at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941, to March 2 1944 and that I last saw her alive on March 2 1944.

Immediate cause of death Thrombocytopenic Purpura Secondary
Due to Measles
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 5 days, 6 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliot M. Johnson M.D.
Address 3432 Frederick Ave Date signed 3/10/44

G 14704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 14704 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3714 Pennington Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5 3
(e) Length of stay in Baltimore (yrs., mos., or days) All life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Pennington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Charles Brown
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1890

8. AGE: Years	Months	Days	If less than one day
53	3	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Joseph Smolenskie
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Preiss
15. Birthplace Germany

16 (a) Informant Cecil Brown
(b) Address 1521 Clement St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 4th 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Dr. G. Bo. Md.

18 (a) Funeral director Charles F. Dell
(b) Address 1501 E Fort Ave.

19 (a) (Date rec'd by registrar) (b) Hunting for William Brown

MAR 3 1944 VS

MEDICAL CERTIFICATION

29. DATE OF DEATH Feb. 29 1944 at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1944 to — 19—, and that I last saw h alive on Feb. 27 1944.

Immediate cause of death Heart failure — Duration

Due to Auricular fibrillation

Due to Generalized Carcinoma metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Imre Neubauer M. D.
Address 1211 Diver St. Date signed Feb. 29 1944

IMRE NEUBAUER, M.D.

G 14705

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 157E

Registered No. # 14705

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens Ave
(c) Hospital or institution: St. Agnes Hosp 251
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1540 Gilpeun & Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Schmelzer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 13, 1944.

8. AGE: Years	Months	Days	If less than one day
—	—	20	hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Andrew Schmelzer

13. Birthplace Md.

MOTHER 14. Maiden Name Anna Helen Fitzmaurice

15. Birthplace Md.

16 (a) Informant Abbie - St. Agnes Hosp.
(b) Address Wilkins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-44 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director Geo. L. Schwab
(b) Address 2101 Frederick Ave. Huntington (Baltimore), Md.

19 (a) Date received by local registrar (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3 1944 at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1944 to 3-3 1944 and that I last saw h[illegible] alive on 3-3 1944

Immediate cause of death Congenital Transposition of the Aorta & Pulmonary Artery

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Transposition of Great Vessels

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. E. Gross M.D. M.D.
Address St. Agnes Hosp Date signed 3/3/44

G 14706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14706 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5502 Hilltop Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Emelda Starr
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ Albert E. Starr Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20th 1872

8. AGE: Years	Months	Days	If less than one day
71	10	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nicholas Schmidt
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Benson
15. Birthplace

16 (a) Informant Mrs Raymond Smith
(b) Address 408 Hopkins Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1247 St. Paul St.

19 (a) MAR 4 1944 (Date rec'd by registrar) Attesting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944 to Mar 3 1944, and that I last saw her alive on Mar 2 1944.

Immediate cause of death	Duration
Due to Hemiplegia	5 mos
Due to Hypertension	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard F. Warner M. D.
Address 2404 Garrison Blvd Date signed 3-3-44

VS 180

G 14707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 830

Registered No. G 14707

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1758 Annapolis Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1758 Annapolis Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE B. SPROW Jr.

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband or~~ wife Estella B. Sprow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21st 879

8. AGE: Years	Months	Days	If less than one day
64	2	8	hr. min.

9. Birthplace Harpers Ferry W. Va. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Guard (Shipping Com.)

FATHER
12. Name George B. Sprow
13. Birthplace Va

MOTHER
14. Maiden Name Mary Jane Gumm
15. Birthplace Pa.

16 (a) Informant Estella B. Sprow
(b) Address Stony Shore Pa.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul st.

19 (a) MAR 4 1944 (b) Registrar
(Registered by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1944, at 5-25 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Wollenmuber M.D.
Medical Examiner.
Date signed 3-1-44

E 14708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14708 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mellie S Bentham

3 (b) If veteran, name war: No | 3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23. 1869

8. AGE: Years 74 | Months 2 | Days 9 | If less than one day: hr. min.

9. Birthplace Coshocton Ohio (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace

16 (a) Informant Harold Bentham
(b) Address 3815 Harwatta Ave

17 (a) Burial (b) Date thereof 3/4/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Hopeful Lutheran
Location Florence Kentucky

18 (a) Funeral director Wilhelm & Son
(b) Address 1217 E Fayette St

MAR 4 - 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to 3/2 1944 and that I last saw b[illegible] alive on Mar 1 1944.

Immediate cause of death: Cardio-vascular hypertensive disease — Duration 6 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer L. Todd MD

Address 735 N Fulton Ave Date signed 3/2/44

VS 150

14709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G 14709 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 N Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma T Kramer

3 (b) If veteran, name war — NW
3 (c) Social Security Account No. none
4. Sex — Female
5. Color or race — White
6 (a) Single, married, widowed, or divorced — Widow
6 (b) Name of husband or wife — John W Sr
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 23 1860
8. AGE: Years 83 Months 6 Days 7 10 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name Lewis G Scherzer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Grund
15. Birthplace Germany

16 (a) Informant Mrs Jane Shirley
(b) Address 509 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1310 E Fort Ave

19 (a) MAR 8 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5 1944 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 19 to March 3 1944 and that I last saw h-r alive on Mar 2 1944

Immediate cause of death: cerebral thrombosis — Duration: 12 hours
Due to: arteriosclerosis — 6 mo.
Due to: old age
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Everett H Mortimer Jr M. D.
Address 270 St Paul St Date signed 3/3/44

G 14710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14710 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5121 Liberty Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5121 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Mary Tyler

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George M.D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1854

8. AGE: Years 89 Months 7 Days 15 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Jacob Linderman

13. Birthplace Md

14. Maiden Name Elizabeth Bergen

15. Birthplace Md

16 (a) Informant Mary D. Tyler

(b) Address 5424 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Md

18 (a) Funeral director Wilson Lee Fox

(b) Address 1217 E. Fayette St

MAR 4 - 1944 (Date rec'd by Registrar) (b) Burlington Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1940 to Mar. 3 1944 and that I last saw h[illegible] alive on Feb 29 1944.

Immediate cause of death Chronic Myocardial Degeneration — Duration 6 yrs

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation no operation

Major findings of operation:

of autopsy: no autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua A. Amoss M. D.

Address 6419 Windsor Mill Rd Examined Mar. 3, 1944

Baltimore - 7

VS 150

G 14711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6

Registered No. G 14711

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d.
(e) Length of stay in Baltimore (yrs., mos., or days) many years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, give township) 3405 Boston St. and (If rural give location)
(d) Street No. Sydenham Hospital
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME KINKLE, Margaret (alias Elizabeth)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Div.

6 (b) Name of husband or wife Floyd Kinkel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1. 1895

8. AGE: Years	Months	Days	If less than one day
49	0	20 21	hr. min.

9. Birthplace Baltimore County (Town, county, and state)
10. Usual Occupation hospital worker
11. Industry or business at Sydenham

FATHER
12. Name John McClelland
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna ? Kirn
15. Birthplace Maryland

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 4/44 (month) (day) (year)
(c) Cemetery or crematory St. Matthew
Location Odonnell St

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. Wolfe St.

19 (a) (b) (Registrar) Huntington Williams, M.D. Registrar

MAR 4 - 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 8 39 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1944. to Mar 2 1944. and that I last saw her alive on Mar 2 1944

Immediate cause of death: meningitis — Duration: 10 days

Due to: meningococcus

Due to:

Other Conditions: pneumonia + pneumococcal septicaemia — ? 2 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 3-2-44

G 14712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G 14712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secour Hospital
(c) Hospital or institution: West Fayette Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 South Milton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Czapiewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-2091

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sabina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/27/1883

8. AGE: Years	Months	Days	If less than one day
60	2	6	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name Stanislaw Czapiewski
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Sabina Czapiewski
(b) Address 801 South Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson Street

MAR 4 1944 (a) (b) Registrar
(Date rec'd by Local Registrar)

VS 3

Hunting for Illness, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1944, to 3-3 1944, and that I last saw h/m alive on 3-2 1944.

Immediate cause of death: Hypostatic Pneumonia — Duration

Due to Generalized Carcinomatosis

Due to Cardiac Decompensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: 2-16-44

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel, Jr. M. D.
Address Bon Secour Hosp. Date signed 3-3-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

K 15

G 14713 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Lanvale Ave
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster, (If outside city or town limits, write RURAL and give town)
(d) Street No. 19½ Park Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Mrs. Bertha L. Shubkagle

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-14-8073

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated

6 (b) Name of husband or wife Albert R.
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1884

8. AGE: Years	Months	Days	If less than one day
59	3	23	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Reese
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida Long
15. Birthplace Maryland

16 (a) Informant Albert R. Shubkagle
(b) Address 19½ Park Ave. Westminster Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day), (year)
(c) Cemetery or crematory St. John's Lutheran
Location Westminster, Md.

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md.

19 (a) MAR 4 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 3 1944, at 4.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 1 1944, to 3 - 3 1944, and that I last saw ~~him~~ alive on 3 - 3 1944.

Immediate cause of death Tuberculous peritonitis — Duration .....
Due to .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Young Jr. M. D.
Address Md. Gen. Hosp Date signed 3-9-44

VS 3

G 14714
450274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57D

G 14714
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Mast St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Randall Hendrix
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-18-34
8. AGE: Years 9 | Months 2 | Days 25 | If less than one day hr. min.
9. Birthplace ~~Child~~ Kentucky (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name H. G. Hendrix
13. Birthplace Arkansas

MOTHER
14. Maiden Name Jane Mills
15. Birthplace Kentucky

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto, Md.

MAR 4 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 3 1944, at 5:25A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1944, to MAR 3 1944, and that I last saw h.i M alive on MAR 3 1944.

Immediate cause of death: Respiratory failure
Due to: Brain tumor
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration: over

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaye, M.D.
Address J H H
Date signed 3/7/44

G 14715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48a

Registered No. G 14715

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4729 Amberly Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4729 Amberly Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE FLORENCE MAIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Roy E. Main
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1899

8. AGE: Years	Months	Days	If less than one day
44	10	12	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Aetna Shirt Co.

FATHER
12. Name Wm. H. Clark
13. Birthplace N. C.

MOTHER
14. Maiden Name Ella P. Bishop
15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. Wm. H. Clark
(b) Address 117 Osborne Ave., Catonsville

17 (a) Burial (b) Date thereof 3/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 4 - 1944
(Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1944, at 5:40 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to March 1 1944, and that I last saw her alive on March 1 1944.

Immediate cause of death Carcinoma of Cervix — Duration 18 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 3321 Frederick Ave Date signed March 2, 1944

G 14716

JO #54343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92C

G 14716

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs 11 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town, give county and state)
(d) Street No. 608 N. Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

1626

3 (a) FULL NAME: William Martin

3 (b) If veteran, name war: ✓

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1871

8. AGE: Years 72 Months 3 Days 13 If less than one day hr min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Old Age Pensioner

11. Industry or business

FATHER
12. Name Francis A. Martin (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances E. Oddenwald (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) MAR 4 - 1944 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1944, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1940 to 3-2 1944.
and that I last saw h[illegible] alive on 3/2 19 44.

Immediate cause of death: Pneumonia

Duration: 7

Due to: Rheum. Ht. Endo - Cardiac

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mall M.D.
Address B. C. H. Date signed 3/2/44

14717 7450237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G 14717
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Smith
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-17-93

8. AGE: Years	Months	Days	If less than one day
50	11	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Jim Smith
13. Birthplace Va
14. Maiden Name Jeanette Smith
15. Birthplace Va

16 (a) Informant Ricarda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/44 (month) (day) (year)
(c) Cemetery or crematory
Location New Port News, Va

18 (a) Funeral director Ebron Wilson
(b) Address 1000 Bryant Ave Newport News, Va

19 (a) 4-6-1944 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 19 44 to Mar 1 19 44 and that I last saw her alive on Mar 1 19 44

Immediate cause of death	Duration
Spontaneous rupture & aneurysm of ascending arch of carotid artery	4 mos (?)
Due to Syphilis (Wass pos)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: 3-2-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bunch M.D.
Address Johns Hopkins Hosp Date signed 3-

14718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14718

Registered No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Canal Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1943

8. AGE: Years	Months	Days	If less than one day
	8	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name David Jackson Sr.
13. Birthplace Va

MOTHER
14. Maiden Name Florence Jackson
15. Birthplace Va

16 (a) Informant David Jackson Sr.
(b) Address 1200 Canal Court apt 42

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley Ave

19 (a) MAR 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rickets

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 3, 1944

G 14719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87E

G 14719 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40th & Keswick
(c) Hospital or institution Home for Incurables 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2805 St Paul
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD HAYWARD TRIPPE

3 (b) If veteran, name war Spanish Amer.

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Florence Dawson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18 1876

8. AGE: Years 67 Months 9 Days 15 If less than one day hr. min. 16

9. Birthplace Easton Md
(Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business

FATHER 12. Name Richard J. Tripp

13. Birthplace Talbot Co Md

MOTHER 14. Maiden Name Annie R. Townsend

15. Birthplace Md

16 (a) Informant A. Maurice Dawson

(b) Address 2805 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 6 44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Henry M. Rankin & Son

(b) Address McCulloh & Druid Hill

19 (a) Huntington Williams, M.D. Registrar

MAR 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944, at 6 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1943 to March 4 1944 and that I last saw him alive on 3/4 1944.

Immediate cause of death Right Hemiplegia — Duration 5 Days

Due to Arteriosclerosis (Dem) — 5 yrs

Due to

Other Conditions Huntington's Chorea — 20 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hargett

Address 214 Medical Arts Bldg Date signed 3/4/44

G 14720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 14720

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: Franklin Square 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5833 Belair Rd (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Margaret W. Bilzer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife John H. Bilzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14-1909

8. AGE: Years	Months	Days	If less than one day
34	5	19	hr. min.

9. Birthplace Balto, Md (Town, county and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER
12. Name Robert E. Riggin
13. Birthplace Md

MOTHER
14. Maiden Name Winifred Wolfe
15. Birthplace Md

16 (a) Informant John H. Bilzer
(b) Address 5833 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Leonard J. Nagle
(b) Address 1215 Harford Ave

19 (a) MAR 4 - 1944 (Registered by registrar) Hunting for Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3-44 19 , at 10:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14-44 19 , to 3-3-44 19 , and that I last saw her alive on 3-3-44 19 .

Immediate cause of death: Myocardial Failure
Due to: Hypertensive C. V. Renal Disease
~~Due to~~
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Block
Address Franklin Square Hosp Date signed 3-3-44 M. D.

G 14721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 14721
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4901 Roland Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

27-14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4901 Roland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie C. Ruark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Lafayette Ruark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1862

8. AGE: Years	Months	Days	If less than one day
81	8	16 17	hr. min.

9. Birthplace Albany, N. Y. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Chamberlain
13. Birthplace N. Y.

MOTHER
14. Maiden Name Christina Rockefeller
15. Birthplace N. Y.

16 (a) Informant Mrs. Christina R. Baker
(b) Address 4901 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Rehoboth Presbyterian
Location Rehoboth, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1908 Eutaw Place

MAR 4 - 1944 (Date rec'd by registrar)
(b) Huntingtown Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1944, at 10:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 19 44 to 3/3/44 19, and that I last saw h[illegible] alive on 3/3/44 19.

Immediate cause of death: Arteriosclerotic Renal Disease
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack R. Morgan M. D.
Address 6 E. Read St. Date signed

G 14722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 14722 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 Eastland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Eastland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernardo Bonita (Bernard L. Bonita) Bernardo Bonita

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gertrude Bonita

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) June 19, 1894

8. AGE: Years 49 Months 8 Days 12 If less than one day hr. min.

9. Birthplace Bourgire. D. N. S. (Town, county and state)

10. Usual Occupation Barber.

11. Industry or business

FATHER
12. Name George Bonita.
13. Birthplace D. N. S.

MOTHER
14. Maiden Name Couture
15. Birthplace D. N. S.

16 (a) Informant Gertrude Bonita.
(b) Address 1908 Eastland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Lyketh Green

18 (a) Funeral director Lyketh Green
(b) Address 804 N. Caroline St.

19 (a) [illegible] 1944 (Registered by registrar) Thursday Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944 at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1944 to March 1 1944 and that I last saw him alive on March 1 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 2 Days.

Due to

Due to

Other Conditions Hypertension — 5 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernardo Bonita

Address 1907 N Caroline Date signed 3/2/44

VS 8

6

G 14723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 14723 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 N. Gay St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Brown (nee Smith)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-3519

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (Mo., day, yr.) Feb 29 1929

8. AGE: Years	Months	Days	If less than one day
34	2 3	2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Nora Duncan
15. Birthplace Maryland

16 (a) Informant Ida May Widmore
(b) Address 412 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem
Location Mt Winans Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1944 at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27, 1944 to March 1 1944 and that I last saw h[illegible] alive on March 1, 1944.

Immediate cause of death: Coronary Thrombosis — Duration 3 da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Odom M. D.
Address 712 E 23d St Date signed 3-4-44

G 14724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 14724 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 Sanford Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Sanford Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Milbourne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Monnie Milbourne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John W. Chappell
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Alice ?
15. Birthplace Md.

16 (a) Informant Monnie Milbourne (Husband)
(b) Address 522 Sanford Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 5 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn A.A. Co Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) MAR 4 (b) 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1944 to Feb 29 1944, and that I last saw him alive on Feb 28 1944

Immediate cause of death: Generalized Peritonitis — Duration: 4 days
Due to Perforation Lower Bowel
Due to
Other Conditions Growth in Lower Bowel (Probably Carcinoma) — undetermined
(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: Man known and with Perforation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature. Ralph L. Upperman, M.D.
Address 1424 E Monument Date signed 3/2/44

VS 150

14725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 14725 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. James Vincent Farrell, C.M.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1885

8. AGE: Years	Months	Days	If less than one day
59	1	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Catholic Priest

11. Industry or business

FATHER
12. Name John Farrell
13. Birthplace

MOTHER
14. Maiden Name Mary
15. Birthplace

16 (a) Informant Rev. Bogart
(b) Address 532 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Zahey & Sons
(b) Address 1827 N. North Ave.

19 MAR 4 - 1944 (Date rec'd by Registrar) (b) Filed by Hilliard M.D. Registrar

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1944, at 1.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1944 to 3/1 1944 and that I last saw him alive on 3/1 1944.

Immediate cause of death: Congestive Heart Failure — Duration 2 days

Due to: Pyelonephritis P.V. Lumbar — 2 yrs.

Due to

Other Conditions: Diabetes mellitus, Cellulitis, Rt. hand — 2 yrs. ~~2 mo.~~

(Include pregnancy within 3 months of death)

Date of operation 2/24/44

Major findings of operation: Incision & drainage Cellulitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature E. Sigmund Sayer M.D.
Address Bon Secours Hosp. Date signed 3/1/44

G 14726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

G 14726 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals 7-R
(d) Length of stay in hospital or inst. (yrs., mos., or days) B-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 N. Luzerne Ave
(Rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Harris

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Craigwell Va.
(Town, county, and state)
10. Usual Occupation Iron-Worker
11. Industry or business U.S. Coast Guard.

FATHER
12. Name Albert Harris
13. Birthplace Va.

MOTHER
14. Maiden Name Viola Jackson
15. Birthplace Va.

16 (a) Informant Gertrude Harris
(b) Address 809 N. Luzerne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6 1944 (month), (day), (year)
(c) Cemetery or crematory St Matthews
Location Edmondson Ave

18 (a) Funeral director Randall Riggs
(b) Address 812 S. Highland Ave

19 (a) MAR 4 1944 (Date received by registrar) (b) Hunting H. Williams, M.D. Registrar

VR 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2-1944, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Meningitis

Due to Probably Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 3-2-44

I HEREBY CERTIFY, THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. ALL ITEMS MUST BE COMPLETED, INCLUDING CAUSE OF DEATH, AS INDEFINITE AND INCOMPLETE DESCRIPTIONS OR IMPROPER TERMS CAUSE UNNECESSARY DELAY IN ISSUING BURIAL PERMITS. Physicians: please write the causes of death clearly and legibly. Be sure that the information concerning the deceased is correct as to name, age, residence, etc., as the certificate cannot be changed after it has been filed with the Registrar. Information as to age is especially important.

G 14727 KASTEN G 14727

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 14727

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Rd.
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Timber Grove Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha V Kasten

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: William J Kasten
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1872

8. AGE: Years	Months	Days	If less than one day
72	1	24	hr. min.

9. Birthplace Adams Co. Penna
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Leonard Shaffbaugh
13. Birthplace Adams Co. Penna

MOTHER
14. Maiden Name Mrs. Burke
15. Birthplace Adams Co. Penna

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 825 N. Calvert St.

19 (a) MAR 5 1944 (Date rec'd by registrar) (b) Huntington Tillmanns, M.D. Registrar

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944, at 11:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1944, to Mar 4, 1944, and that I last saw her alive on Mar 4, 1944.

Immediate cause of death: Pt Cerebral Hemorrhage (a) 1 hr.
Due to Arterio sclerosis
Due to
Other Conditions Arterio sclerosis psychosis. 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas P. Talamo M. D.
Address 33 W. Mt. Ave Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 14728

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2426 Liberty Heights Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 Liberty Heights Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie C. Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Marion L. Elliott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1869

8. AGE: Years	Months	Days	If less than one day
74	6	3 5	hr. min.

9. Birthplace Carroll County, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Henry L. Bressler
13. Birthplace Pa.

MOTHER
14. Maiden Name Rachel Andre
15. Birthplace Md.

16 (a) Informant Marion L. Elliott
(b) Address 2426 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAR 5 1944 (Date rec'd by Local Registrar) Huntington Williams, M.D. (Signature of Local Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941 to March 3 1944, and that I last saw her alive on Feb 28 1944

Immediate cause of death Coronary occlusion — Duration —

Due to arteriosclerosis —

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Fisher Ford — M. D.
Address 20 E. Preston St. Date signed

G 14729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

G 14729 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3022 Garrison Boulevard
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mary Shaw

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Charles W. Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1866

8. AGE: Years	Months	Days	If less than one day
78	1	--	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Henry W. Eastman
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Mary Wentz
15. Birthplace Md.

16 (a) Informant Miss Anna F. Shaw
(b) Address 3022 Garrison Boulevard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

MAR 5 1944 (Date) Huntington Williams M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Mar 3 1944, and that I last saw h alive on Feb 1 1944.

Immediate cause of death: uremia, nephritis, cardio vascular renal disease chronic

Duration: 4 years

Due to: Acute Uremia

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Luther P. Leitch M. D.
Address 10 W. Madison St. Date signed

D. Certificate = 1-3

G 14730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830a

G 14730 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Bolton St.
(c) Hospital or institution:
none

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Bolton St.
(If rural give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3 (a) FULL NAME Sandusky Dozier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Josephine Llewyn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1848

8. AGE: Years	Months	Days	If less than one day
95	8	28 24	hr min

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Samuel Dozier
13. Birthplace Va.

MOTHER
14. Maiden Name Lovey Ann Etheridge
15. Birthplace Va.

16 (a) Informant Mrs. Marion I. D. Rogers
(b) Address 1518 Bolton St.

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof March 8, '44
(month) (day) (year)

(c) Cemetery or crematory
Location Elmwood Norfolk, Va.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

MAR 5 1944
(Date rec'd by registrar)

19 (a) Filed by Huntington Williams, M.D.
(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1944, at 4.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-29 1944 to 3-4 1944 and that I last saw h alive on 3-3 1944.

Immediate cause of death: Cerebral hemorrhage
Due to: left hemiplegia
Due to: art. sclerosis
Due to: senility.

Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Dr Bernard J. Cohen M. D.

Address Marlborough Apts. Date signed

447807 G 14731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47C

G 14731

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days

(e) Length of stay in Baltimore (yrs., mos., or days) 47 days

2. USUAL RESIDENCE OF DECEASED:

(a) State VA (b) County

(c) City or town DUNCANNON (If outside city or town limits, write RURAL, and give town)

(d) Street No. 317 MARKET (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME DONALD B TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	MARRIED

6 (b) Name of husband or wife ADELE W

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 11-28-02

8. AGE: Years	Months	Days	If less than one day
41	3	6	hr min

9. Birthplace VA (Town, county, and state)

10. Usual Occupation MACHINE SHOP OWNER

11. Industry or business

FATHER 12. Name WILLIAM TAYLOR

13. Birthplace MICH

MOTHER 14. Maiden Name ADELE BEALL

15. Birthplace MO

16 (a) Informant RECORDS

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 3/4/44 (month) (day) (year)

(c) Cemetery or crematory Duncannon Cem

Location Duncannon Pa.

18 (a) Funeral director William Cook

(b) Address 217 N Front St

MAR 6 1944 (Date rec'd by registrar) Huntingtown Williamsport MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 4 1944, at 2:11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 16 1944, to MAR 4 1944, and that I last saw h I M alive on MAR 4 1944

Immediate cause of death Respiratory failure — Duration 2 wks

Due to Pneumonia

Due to

Other Conditions Metastatic Carcinoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. S. Spencer M. D.

Address Johns Hopkins Hospital Date signed 3-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14732

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14732 Registered No. 561

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st Remington Ave., and 31st St.,
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 ds.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County
(c) City or town New London (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Hawthorne Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Simplicio Palomata

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW-2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Filipino	married

6 (b) Name of husband or wife Geraldine Martin
6 (c) If alive, give age 18 years

7. Birth date of deceased (mo., day, yr.) 12/24/13

8. AGE: Years	Months	Days	If less than one day
30	2	10	hr. min.

9. Birthplace Phillippine Islands (Town, county, and state)
10. Usual Occupation Steward 3/c
11. Industry or business

FATHER
12. Name Pedro Palomata
13. Birthplace P.I.

MOTHER
14. Maiden Name Frances
15. Birthplace P.I.

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4 1944 (month) (day) (year)
(c) Cemetery or crematory New London Conn.
Location
18 (a) Funeral director Pott & B M Walters
Address 1944 Stricker St
MAR 5

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1944, at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11, 1944 to March 4, 1944, and that I last saw him alive on March 4, 1944.

Immediate cause of death
~~Tuberculer meningitis~~; ~~Tuberculosis of brain stem.~~
Due to Lapt of Brain stem
Due to Undetermined cause.
Other Conditions
(Include pregnancy within 3 months of death)

Duration
4 wks.

Date of operation
Major findings of operation: None
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. C. S. Brace
US Marine Hospital
Address Baltimore, Md. Date signed 3/4/44 M.D.

G 12733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14733 Registered No. 46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Elizabeth City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Harrington Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Kenton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James J. Quidley
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Scarborough
15. Birthplace N.C.

16 (a) Informant Daughter
(b) Address 21 LaFayette Rd, Vestal, N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mabel 7- (month) (day) (year)
(c) Cemetery or crematory
Location Elizabeth City - N.C.

18 (a) Funeral director Ellsworth Chypoos
(b) Address 3911 Liberty Heights Ave

MAR 5 1944 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/44 19 . at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1944. to 3/4 1944. and that I last saw her alive on 3/4 1944.

Immediate cause of death	Duration
Carcinoma of stomach	
Due to Coronary occlusion & stroke of operation procedure	
Due to	
Other Conditions Carcinoma of stomach, diabetes	

(Include pregnancy within 3 months of death)

Date of operation 3/4/44
Major findings of operations Carcinoma of stomach & pylorus adhering
of autopsy: Carcinoma stomach & Ca of stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Lyons M. D.
Address University Hospital Date signed 3/4/44

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

✓ G 14734 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1052 Durham Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RFD, and give town)

(d) Street No. 1052 Durham Street (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Edna Lane Todd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Raymond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1913

8. AGE: Years	Months	Days	If less than one day
33	11	24	hr min

9. Birthplace Madison Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Linthicum

13. Birthplace Madison Md.

MOTHER 14. Maiden Name Sophie Chase

15. Birthplace Madison Md.

16 (a) Informant Raymond Todd

(b) Address 1082 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7 '44 (month) (day) (year)

(c) Cemetery or crematory

Location Madison Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Dgt

(b) Address 1124 N. Gaudine St.

19 MAR 5 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944, at 8 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 1 1944, to March 3 1944, and that I last saw h[illegible] alive on March 2 1944

Immediate cause of death

Cardio vascular disease

3 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify) (Place)

(e) Means of injury

23. Signature R. M. Pruett M. D.

Address 1422 E. Chase Date signed 3-4-'44

(over)

G 14735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 14735
Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3513 REIST RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2 USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 3513 REIST RD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS SCHILLER

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: LENA
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 77 | Months | Days | If less than one day: hr min
9. Birthplace: LATVIA (Town, county, and state)
10. Usual Occupation: FURNITURE SELF
11. Industry or business

FATHER
12. Name: SOLOMON
13. Birthplace: LATVIA

MOTHER
14. Maiden Name: SARAH
15. Birthplace: LATVIA

16 (a) Informant: WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-5-44 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO & CONKLIN ST

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Balt St

MD 3-1944 (Date rec'd by Registrar) (b) [illegible] Williams Registrar

VS 150 D

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3-44 19 , at 9 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1943 to 3-4- 1944, and that I last saw [illegible] alive on 3-3- 1944

	Duration
Immediate cause of death: arterio-sclerotic heart disease	1943
Due to arterio sclerosis cor. nephritis	1944
Due to general arterio sclerosis	
Other Conditions Coronary thrombosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R A Michelson M. D.
Address 2270 Eutaw Place Date signed 3/4/44

G 14736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14736 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Li
(c) Hospital or institution Sinai Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4002 Springdale Ave (Rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max H. Krauss.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	wh.	Widow

6 (b) Name of husband or wife Belle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 84 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-44 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Dolan Rd.

18 (a) Funeral director Jack Lewis Inc.
(b) Address 2402 Eastern Ave.

19 (a) (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1944, at 3:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944, to 3/3 1944, and that I last saw him alive on 3/3 1944

Immediate cause of death Respiratory failure — Duration

Due to Cerebral arterial thrombosis

Due to Arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leonard Akman M. D.
Address Sinai Hosp Balt Date signed 3/3/44

G 14737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 14737 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Raynor Ave & Uhland Rd

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3919 Beaumont Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country Russia

3 (a) FULL NAME mr. Louis Friedland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1881.

8. AGE: Years	Months	Days	If less than one day
62 63	10	24	hr. min

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired Presser

11. Industry or business

FATHER 12. Name Israel Friedland

13. Birthplace Russia

MOTHER 14. Maiden Name Leah E. Rudolph

15. Birthplace Russia

16 (a) Informant Mrs. Bessie Friedland

(b) Address New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 5/44 (month) (day) (year)

(c) Cemetery or crematory New York NY

Location

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-26 W. North ave.

MAR 5 1944 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944, at 11:06 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1944 to 3/4 1944, and that I last saw h[illegible] alive on 3/4 1944.

Immediate cause of death angina Heart failure — Duration

Due to Arteriosclerotic cardio vascular lesions

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis Baldwin

Address West Baltimore General Hospital Date signed 3/4/44 M.D.

G 14738 ✓ G 14738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3050 Tioga Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Friedman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife Late Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name Meyer Friedman
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Joel G. Hochman
(b) Address 3050 Tioga Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

MAR 5 - 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3 1944 at 7⁸⁰ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1944 to 3-3 1944 and that I last saw h alive on 3-3 1944.

	Duration
Immediate cause of death Cardiac failure	3 months
Due to Coronary thrombosis	1
Due to arteriosclerosis	2
Coronary arteries	1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. M. Friedman M. D.
Address West Bal Health Date signed 3/3/44

G 14739 G 14739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3900 Bonner Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 Bonner Road (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Jacob Edelstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Yetta
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years: 73 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation .....

11. Industry or business Merchant

FATHER
12. Name .....
13. Birthplace Russia

MOTHER
14. Maiden Name .....
15. Birthplace Russia

16 (a) Informant Sol Edelstein
(b) Address 3900 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Roa d
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) ..... (b) ..... Registrar
(Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION 8.00

20. DATE OF DEATH March 4 1944 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1942 to March 3 1944
and that I last saw him alive on March 3 1944

Immediate cause of death: Coronary occlusion — Duration

Due to Aortic stenosis ? insufficiency; arteriosclerosis.

Other Conditions Emphysema of bladder - Hernia

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature P Murphey M. D.
Address 2301 Park Ave Date signed 3/4/44

G 14740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14740

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 ParkHeights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 Oswego Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Yetta Friedman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Late Simon
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation .....

11. Industry or business House Work

FATHER 12. Name Louis Sandler
13. Birthplace Russia

MOTHER 14. Maiden Name Fannie Rachel
15. Birthplace Russia

16 (a) Informant Mrs Lewis Pass
(b) Address 2620 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) MAR 6 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1944, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 27 1944 to 3/4 1944, and that I last saw h alive on 3/4 1944.

Immediate cause of death Acute Cerebral Hemorrhage — Duration

Due to Ch arteriosclerosis

Due to Ch Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature A. H. Hornstein M. D.
Address 733 Anzuith St Date signed 3/4/44

G 14741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 14741

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3413 E. LOMBARD ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 E. LOMBARD ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD J. EINERSEN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: CAROLINE EINERSEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 2 1868

8. AGE: Years 75 | Months 3 | Days 0 | If less than one day: hr. min.

9. Birthplace DENMARK (Town, county, and state)

10. Usual Occupation RETIRED MOTORMAN

11. Industry or business BALTO. TRANSIT CO.

FATHER
12. Name HERALD EINERSEN
13. Birthplace DENMARK

MOTHER
14. Maiden Name JULIANNA DEIGN
15. Birthplace DENMARK

16 (a) Informant MRS. BECK (DAUGHTER)
(b) Address 3413 E. LOMBARD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 6/44 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) 1944 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 2 1944, at 1/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to Mar 2 1944.
and that I last saw h[im] alive on 2/10 1944.

Immediate cause of death
Chr. Myocarditis
Chr. Nephritis
Due to Hypertension
Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Joseph Lenhart M.D.
Address 441 E. Fleet Ave. Date signed 3/3/44

G 14742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58E

G 14742 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Fairfield Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Fairfield Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank L. Ware

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 216-10-3311

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1893

8. AGE: Years 50 | Months 7 | Days 27 | If less than one day: hr. min.

9. Birthplace A. A. Co., Md (Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business Shipyard

FATHER
12. Name Frank L. Ware Sr.
13. Birthplace Md

MOTHER
14. Maiden Name Mildred Norris
15. Birthplace Md

16 (a) Informant Bertha A. Ware
(b) Address 3205 Fairfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Et
Location A. A. Co Md

18 (a) Funeral director Isaiah L. Brown Sr
(b) Address 108 W Montgomery St

19 (a) (Signature of registrar) (b) Registered

MAR 6 1944

VS 150

Huntington Terrace

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 19 44 to Mar 1 1944, and that I last saw h[illegible] alive on 2/1 19 44.

Immediate cause of death: Ac Myocarditis — Duration: 2 Day
Due to: Rheumatic Fever — 14 Days
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. N. Hatcher
Address 1 V 25 Par Date signed 3/4/44

G 14743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1939

G 14743 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia D. Watkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Married

6 (b) Name of husband or wife Arthur S. Watkins

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Dickerson
13. Birthplace Penna.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Arthur S. Watkins
(b) Address 1603 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-1944 (month) (day) (year)
(c) Cemetery or crematory St. Anne's
Location Annapolis & A.A.Co. Rd.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 (a) (Date rec'd by Registrar) MAR 5 1944 (b) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16 1941 to 3/2/ 1944 and that I last saw h er alive on Feb. 28, 44.

Immediate cause of death
Hypertensive cardio vascular disease — Duration ?

Due to

Due to

Other Conditions — — — —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Weiss M. D.
Address 1226 Hanover St. Date signed 3/4/44

4

G 14744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 14744

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 W. Lefington
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	B	widowed

6 (b) Name of husband or wife semkown - dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1878

8. AGE: Years	Months	Days	If less than one day
65	4	23	hr. min.

9. Birthplace Md.
(Town, county and state)

10. Usual Occupation Blind -

11. Industry or business

FATHER
12. Name John Brown
13. Birthplace

MOTHER
14. Maiden Name Eliza Griffen
15. Birthplace

16 (a) Informant George V. Lattier
(b) Address 1609 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7, 19 (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Mrs George V. Hallam
(b) Address 1681 Druid Hill Ave

19 (a) MAR 5 - 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1944 to 3-2 1944, and that I last saw h. alive on 3-2 1944.

Immediate cause of death	Duration
Pulmonary Embolus	
Due to Gangrene of Lt leg	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-19-44

Major findings of operation: Mid. thigh amputation

If autopsy: for gangrene

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thornton Platt M. D.
Address Univ. Hosp Date signed 3-3-44

VS 8

G 14745 — G 14745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 Hanover
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Hanover St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Caroline Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W	

6 (b) Name of husband or wife John W Smith (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	9	25		

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER — 12. Name William Harmon
13. Birthplace Va

MOTHER — 14. Maiden Name Tillie Mears
15. Birthplace Keller Va

16 (a) Informant John Smith
(b) Address 609 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

MAR 5 — 1944 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1944 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to March 1944, and that I last saw h alive on March 1, 1944.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertensive Cardio Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 805 N. Eutaw Date signed

Thanks for William #8

G 14746

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14746 Registered No. 92 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1832 W Baltimore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 W Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J Vincent Doughterty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28 1894

8. AGE: Years 69 Months 6 Days 3 If less than one day: hr. min.

9. Birthplace Maryland
(town, county, and state)

10. Usual Occupation Photo Engraver

11. Industry or business

FATHER 12. Name Jno. B Dougherty

13. Birthplace Md

MOTHER 14. Maiden Name Annie E Steil

15. Birthplace Baltimore Md

16 (a) Informant Miss Grace Dougherty

(b) Address 1832 W Baltimore

17 (a) Burial (b) Date thereof 3-6-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo A Tinley

(b) Address Fulton & Fayette

MAR 5 - 1944 (b) Huntington Hill Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2 - 1944 at 11.36 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1944 to Mar. 2 1944 and that I last saw him alive on Mar. 2 - 1944

Immediate cause of death — Duration

Mitral Regurgitation — 2 yrs

Due to

Cerebral Embolism — 2 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac C. Dickson, M. D.

Address 3055 N. North Ave. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 14747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 Gorsuch Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Gorsuch Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie J. Couturier

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Louis Coulourieux
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1874

8. AGE: Years	Months	Days	If less than one day
69	10	3	hr. min.

9. Birthplace France (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Chas. Dubraud
13. Birthplace France

MOTHER
14. Maiden Name Louise Ravellou
15. Birthplace France

16 (a) Informant Mrs Theresa Hood
(b) Address 916 Gorsuch Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave

18 (a) Funeral director Wendell E. Humphreys
(b) Address 1801 N. Broadway

19 (a) MAR 6 - 1944 (Date received by registrar) (b) Clinton Hillcoat, a Registrar, Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944, at 5 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944, to March 4 1944, and that I last saw her alive on March 3 1944

Immediate cause of death	Duration
Mitral Regurgitation Decompensation	4 d.
Due to Chr. Parenchymatous Nephr.	4 d
Due to	
Other Conditions Diabetes Mellitus	4 y.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. J. A. Storms
Address 2878 Stanford Date signed 3-5-44 M. D.

G 14748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. G 14748

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 S. Eutaw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Ray Bollinger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife — —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 12 1937

8. AGE: Years	Months	Days	If less than one day
7	1	2320	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name Arnel L Bollinger
FATHER 13. Birthplace Baltimore
MOTHER 14. Maiden Name Katherine Merrymen
MOTHER 15. Birthplace Baltimore

16 (a) Informant Katherine Bollinger
(b) Address 314 S. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Charles Kuchanskas
(b) Address 637 Washington Blvd

19 (a) MAR 6 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1- 1944, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Skull

Due to

Other Conditions Fractured neck.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-1-44 at 12 00 P 21/2 M.
(b) Where did injury occur? Washington Blvd & W. J Mason
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto-truck

23. Signature Howard J. Wallace M.D. Medical Examiner.
Date signed 3-2-44

VS 151

14749 ✓ G 14749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs. (64 days?)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Eleanor Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie Lees (ANNIE Elizabeth Lees)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Wm. Geo. Lees.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1872

8. AGE: Years 71 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Philadelphia
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thos. M. Boyle
13. Birthplace Philadelphia - Pa.

MOTHER
14. Maiden Name ANNIE Rosanna Evans
15. Birthplace ? - Md.

16 (a) Informant Dr. Boyle Lees (Son)
(b) Address Longfellow Hotel - Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 - 9 - 44 (month) (day) (year)

(c) Cemetery or crematory
Location Smyrna - Delaware.

18 (a) Funeral director STEWART & MOWEN COMPANY (W. F. WOODEN SUC.)
(b) Address 108 W. NORTH AVENUE

MAR 6 - 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 1944 at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1944 to 3/4 1944 and that I last saw h[illegible] r alive on 3/4 1944.

Immediate cause of death Carcinoma of lung

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers, M.D.
Address Medical Arts Bldg. Date signed 3/4/44

14750
JL - 85664

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 14750
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Zepp (John Edward Zepp)

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 168-14-0742

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Susen R. Zepp

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1899

8. AGE: Years 44 | Months 5 | Days 20 | If less than one day: hr min

9. Birthplace Pa. (Hanover) (Town, county, and state)

10. Usual Occupation Machinist Helper

11. Industry or business Beth. Steel Shipyard.

FATHER
12. Name David Zepp
13. Birthplace Pa.

MOTHER
14. Maiden Name Alice Rubenstein
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1944 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1944 to 2/27 1944. and that I last saw him alive on 2/27 1944.

Immediate cause of death: Lobar Pneumonia — Duration 5 d.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seymour M.D.
Address BCH Date signed 3/2

G 14751

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 460

G 14751 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Kenyon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Kenyon Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME HARRY G. RUTTER

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No. none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Clara V. 1873
6 (c) If alive, give age ~~1873~~

7. Birth date of deceased (mo., day, yr.) June 12, 1873

8. AGE: Years 70 ~~71~~ Months 8 Days ~~22~~ If less than one day: hr. min

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Retired Internal Revenue
11. Industry or business

FATHER
12. Name Joseph Rutter
13. Birthplace Balto.

MOTHER
14. Maiden Name -- Gill
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Clara V. Rutter
(b) Address 3401 Kenyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received MAR 6 - 1944 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1936 to Mar 3 1944, and that I last saw h[illegible] alive on Mar 3 1944

Immediate cause of death Cardiac Failure — Duration 1-2 days

Due to Hypertension Myocarditis — Duration years

Due to

Other Conditions Prostate Carcinoma
& Rectum
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury

23. Signature George J. Bayly, Physician, M.D. Chesapeake Br. & Balto Pa
Date signed 3/6/44

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 150

G 14752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

G 14752 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Aves
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a. State Md. b. County
c. City or town Baltimore (29) Md.
(If outside city or town limits write (R.F.D.) and give town)
d. Street No. 337 Lawyn Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME C. Edward Meyer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1927
8. AGE: Years 16 | Months 9 | Days 16 | If less than one day: hr min
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name John Meyer
13. Birthplace Maryland

MOTHER
14. Maiden Name Pauline Shriber
15. Birthplace Pennsylvania

16 (a) Informant Mr. John Meyer
(b) Address 337 Lawyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson & Longwood St

18 (a) Funeral director Harry A. Welty
(b) Address 1016 Edmondson Ave.

19 (a) MAR 6 - 1944 (Date filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2 1944 at 1:28 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1-4 1944 to 3-2 1944 and that I last saw h/m alive on 3-2 1944

Immediate cause of death: Retroperitoneal Sarcoma with extensive lymph node involvement — Duration

Due to

Due to

Other Conditions

(Include operations within 3 months of death)

Date of operation Cystoscopy 1-7-44

Major findings of operation: Mass at vesicle neck mass involves bladder & prostate

Autopsy: Retroperitoneal Sarcoma (Finally)

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature W. E. McGrath M.D. M.D.
Address St. Agnes Hosp. Date signed 3/2/44

G 14753

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92D

G 14753
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3804 Old Frederick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Old Frederick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine A. Hoetzel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widow

6 (b) Name of husband or wife late Charles H. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/1867

8. AGE: Years	Months	Days	If less than one day: hr.	min.
77		27		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Geo. Horn
13. Birthplace Germany

MOTHER
14. Maiden Name — Gerig
15. Birthplace Germany

16 (a) Informant Mrs. Gerhard Kaufhold
(b) Address 3804 Old Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry A. Weitzel
(b) Address 401 E Edmondson Ave.

19 (a) (Date received by registrar) MAR 6 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1944 at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1943 to 3/3 1944 and that I last saw h e alive on 3/1 1944.

Immediate cause of death: Coronary Thrombosis — Duration 2/2 mo

Due to Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23 Signature Eliot W. Hahn M.D.
Address 3432 Juliet Ave Date signed

Please write in ink. Spelling of name and address is especially important. If unknown, state so. Please write the cause of death clearly and legibly.

G 14754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14754 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a State Md b County

c City or town Baltimore (If outside city or town limits, write RURAL and give town)

d Street No. 428 Eversham Ave (If rural give location)

e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Charles Fritsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Myrtle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-7-93

8. AGE: Years 50 | Months 2 | Days 26 | If less than one day: hr min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Meat Cutter

11. Industry or business

FATHER 12. Name Charles Fritsch

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Eleanor Nordbruch

MOTHER 15. Birthplace Md.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 7 (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Rural

18 (a) Funeral director Ullrich Funeral Home

(b) Address 200 S. Broadway

19 (a) (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944 at 7 33 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944 to Mar 3 1944 and that I last saw h alive on Mar 3 1944.

Immediate cause of death: Cardiac insufficiency — Duration

Due to Hypertensive cardio vascular disease

Due to

Other Conditions Pulmonary infarction (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not reported

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John R. Birmingham JHH

Address Date signed 3-3 M D.

G 14755

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

✓ G 14755 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 E. 28th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1908 E. 28th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Cameron

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William Cameron
6 (c) If alive, give age 1873

7. Birth date of deceased (mo., day, yr.) June 6, 1871

8. AGE: Years	Months	Days	If less than one day
70 ~~72~~	8	27 28	hr min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Edward Voelker
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Theresa Dodds
(b) Address 107 Grange Ave. Phila. Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/8/44 (month) (day) (year)
(c) Cemetery or crematory Glenwood Cem.
Location Washington, D.C.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E. Orleans St.

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection / Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D.
Asst. Medical Examiner.
Date signed 3-4-44

(over)

VS 151

14756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 84D

G 14756 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 Evesham Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 Evesham Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MYRTLE FRITSCH HALLER

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Haller

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1919

8. AGE: Years 24 | Months 2 | Days 22 | If less than one day: 2 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles H. Fritsch
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Myrtle Collins
15. Birthplace Baltimore, Md.

16 (a) Informant Eleanor Fritsch,
(b) Address 428 Evesham Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home,
(b) Address 2008 Orleans St.,

19 (a) MAR 6 - 1944 (Date rec'd by registrar) (b) Martin F. Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1944 19 at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 29 1944 to March 3 1944 and that I last saw her alive on March 3 1944

Immediate cause of death: Exhaustion - Starvation - Mental disease — Duration: 1 yr.

Due to: Nervous breakdown following Child birth. — Duration: 2 yrs.

Other Conditions: — Duration: 1941 / 1941

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony F. Lucchesi M. D.

Address 717 Fayette St. Date signed 3/5/44

correct 4/6 if explanatory

JL - 55948 G 14757

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14757 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Banger St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Parker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1887

8. AGE: Years 56 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Railroad Worker

11. Industry or business

MOTHER / FATHER
12. Name John Parker
13. Birthplace ?
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 7/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Wash. Blvd. Balto. Co.

18 (a) Funeral director Ullman Funeral Home
(b) Address 2007 Oakleam St

19 (a) MAR 6 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 19 44, to 3/4 19 44, and that I last saw h[illegible] alive on 3/4 19 44.

Immediate cause of death	Duration
Lobular Pneumonia	7
Due to Cerebral Thrombosis Hemiplegia	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattone M. D.
Address R. F. D. Date signed 3/4/44

PLEASE WRITE—correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Hunting for Williams, [illegible]

14758.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C-14758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: St. Josephis Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 Da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE KOEHNLEIN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Katherine Koehnlein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29 1867

8. AGE: Years	Months	Days	If less than one day
76	10/1	4 5	hr min.

9. Birthplace Balto (Town, county and state)
10. Usual Occupation Machinist (Retired
11. Industry or business

FATHER
12. Name Matthew Koehnlein
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Known
15. Birthplace

16 (a) Informant Mrs Adyle Pluth
(b) Address 1013 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 8/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Oakem St

19 (a) MAR 6 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4 1944 at 9.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1944 to 3-4 1944, and that I last saw him alive on 3-4 1944.

Immediate cause of death: Carcinoma of large bowel & metastasis — Duration: 24 da.
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: 2-14-44 Colostomy
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz
Address St. Josephis Hosp Date signed 3-4-44

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G 14759
Registered No.

Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 + Calvert Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~~18 days~~ 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Talbot
(c) City or town Easton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME S. Stansbury Brady

3 (b) If veteran, name war W.W.#1 awaiting Commission when War ended
3 (c) Social Security Account

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. S. Stansbury Brady
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22 1888

8. AGE: Years	Months	Days	If less than one day
56	1	11	12 hr. — min.

9. Birthplace Baltimore, Maryland (Town, county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John W.S. Brady
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna J. Abel
15. Birthplace Baltimore Md.

16 (a) Informant Hosp. Record
(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mar 6 1944 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Green Mount Baltimore

18 (a) Funeral director Henry H. Jenkins Sons Co.
(b) Address 24 E. Fulton & Orchard St.

19 MAR 6 - 1944 (Date rec'd by registrar) (b) Huntington Registrar

VS 15e

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 March 1944, at 10:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Feb 1944 to 4 Mar 1944, and that I last saw him alive on 4 March 1944.

Immediate cause of death Carcinoma of stomach — Duration Months?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Carcinoma of stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill III M. D.
Address Union Memorial Hosp. Date signed 3-5-44

14760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G 14760

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7/24

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3000 Hudson Street
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvester Dekeen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of ~~husband~~ or wife Mary (nee Schimunek)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Own Business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Milton Kopp)son)

(b) Address 1142 Neucomb, Armistead Gardens

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)

(c) Cemetery or ~~crematory~~ First United Evang.

Location 6115 O'Donnell St. City.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

19 (a) ~~Registrar~~ (Deputy Registrar) (b) MAR 6 1944 Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1944 to March 4 1944, and that I last saw h[illegible] alive on March 4 1944.

Immediate cause of death Acute Cardiac Decompensation

Due to Arteriosclerotic C.V. Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Dr. H. E. Wallace M. D.

Address 1400 N. Caroline St. Date signed 3/4/44

WALL CUP

G 14761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G 14761 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore
(b) Street address 1020 Rice st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 33yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028. Rice st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida. Thompson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
33yr	—	—	hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Jones
13. Birthplace Hertford N.C.

MOTHER
14. Maiden Name Alice Diggs
15. Birthplace Richmond Va.

16 (a) Informant James. Jones
(b) Address 1028 Rice st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory First Bapt. Ch.
Location Hampden Md.

18 (a) Funeral director Chas H Alexander
(b) Address 927. N. Mount st

19 (a) (Date received) 1944 (b) Registrar

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944. at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944. to March 1944.
and that I last saw h alive on March 1 1944.

Immediate cause of death — Duration
Aortic Heart Disease
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 1 W. Mount st Date signed 3/6/44

Correct age is objectively important. Any person who willfully makes any false statement in the statements of death clearly and legibly

Spec.—9-39—A. & Co.—250 Blks.

14762 LAWSON. ✓ G 14762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

839

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 Bruce ST. 17-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Ida Lee Lawson

(a) RESIDENCE NO. 619 Bruce ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos ds. How Long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Paul S. C.

PARENTS

10 NAME OF FATHER Edestor Sawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C

12 MAIDEN NAME OF MOTHER Eliza Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant Louise Richardson

(Address) 709 Edmondson Ave

AR-6-1944 Huntington Hilliard, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/44

17

I HEREBY CERTIFY, That I attended deceased from 2/25/44, 19 44, to 3/3/44, 19 44

that I last saw h alive on 3/3/44, 19 44

and that death occurred, on the date stated above, at 5:20 A m.

The CAUSE OF DEATH* was as follows:

Uremia

Chronic Acute Congestion of the Lungs

(duration) yrs. mos. 7. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Lyon, M. D.

19 (Address) 522 N. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sumter SC — DATE OF BURIAL 3/6/44

20 UNDERTAKER Robt E Williams — ADDRESS 1515 W Eldorado St

G 14763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 14763
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution:

2-7-12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mt. St. Agnes
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Henry P. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-6382

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1887

8. AGE: Years	Months	Days	If less than one day
57	1	13	15 hr min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Janitor at Mt. St. Agnes
11. Industry or business

FATHER
12. Name Peter Henry Thomas
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Joseph Gollickoffer
(b) Address 2242 Booth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-1944
(month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location 2930 Speedwell Ave.

18 (a) Funeral director John Howard & Son
(b) Address 901 Fallsway St.

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar
MAR 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1944, to 3-4 1944, and that I last saw him alive on 3-4 1944.

Immediate cause of death
Congestive heart failure
Due to Coronary infarction
Due to .....
Other Conditions Pneumonia & pleurisy
(Include pregnancy within 3 months of death)

Duration

Date of operation None
Major findings of operation: .....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature John C. Ozaguwolie M. D.
Address Mercy Hospital Date signed 3-7-44

G 14764

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G 14764 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 S. Poppleton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 S. Poppleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Samuel Y. Harris

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Eunice O. Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1867

8. AGE: Years	Months	Days	If less than one day
76	6	22	hr. min.

9. Birthplace Calvert County, Md.
(Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business Self

FATHER
12. Name Mr. Harris
13. Birthplace United States

MOTHER
14. Maiden Name Elizabeth Kracklin
15. Birthplace

16 (a) Informant Mrs. Maude B. Disney
(b) Address 4216 Van Buren University Park, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) MAR 6 - 1944 (Date rec'd by registrar) Hunting for Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1944 to Mar 1 1944, and that I last saw h[illegible] alive on Mar 1 1944.

Immediate cause of death Arterio sclerotic Cardio-vascular Disease — Duration ?

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carl A. Roessing
Address 1326 W. Lombard St. Date signed 3/5/1944 M. D.

VS 180

G 14765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 14765
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Arlington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Arlington Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence C. Willis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 4 - 43

8. AGE: Years	Months	Days	If less than one day
	32	28	hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Laurence Willis
13. Birthplace md

MOTHER
14. Maiden Name Clotelius Coleman
15. Birthplace md

16 (a) Informant Clotelius Coleman
(b) Address 521 N. Arlington ave

17 (a) Burial (b) Date thereof march 6, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location md

18 (a) Funeral director Geo. G. Nelson
(b) Address 1302 Pennsylvania St

19 (a) MAR 6 - (b) 1944
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pneumonia

Due to Extreme malnutrition

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 3, 1944

VS 151

G 14766

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

G 14766 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 N Hugh St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 N Hugh St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Reskovitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Freda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day hr	min.
80				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Medicza Peretz
13. Birthplace Russia

MOTHER
14. Maiden Name Chylya
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Old Fort Hemplton Rd
18 (a) Funeral director Jack Levin
(b) Address 1409 E. Balt St

19 (a) MAR 6 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944 at 8:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 19 44 to March 5 19 44, and that I last saw h[illegible] alive on March 5 19 44

Immediate cause of death

Myocarditis
Due to Acute cardiac dilatation
Due to Chron. bronchitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

1 wk

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M J Bayhan
Address 2040 Eutaw Date signed 3/6/44

G 14767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14767 Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2615 Springhill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Springhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Union

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Nathan Union
(b) Address 2615 Springhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore Md

18 (a) Funeral director Jack Sears & Son
(b) Address 1439 E. Baltimore St

19 (a) 3-6-47 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1947, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1947 to March 5 1947 and that I last saw h[illegible] alive on March 1947.

Immediate cause of death: Bronchopneumonia — Duration: 10 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Lehman M.D.
Address 1946 Mulberry Date signed 3/6/47

Huntington [illegible]

G 14768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G 14768

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3630 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Israel

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex fem
5. Color or race wh
6 (a) Single, married, widowed, or divorced W
6 (b) Name of husband or wife Aaron
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1868
8. AGE: Years 76 Months Days If less than one day hr. min.
9. Birthplace Roumania (Town, county, and state)
10. Usual Occupation none
11. Industry or business

MOTHER / FATHER
12. Name Hyam Cohen
13. Birthplace Roumania
14. Maiden Name Sarah
15. Birthplace Roumania

16 (a) Informant Hyam Cohen
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Rd

18 (a) Funeral director Louis Levine
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 6

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1944, at 12 NOM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944 to 3/5 1944 and that I last saw h. alive on 3/5 1944.

Immediate cause of death Cardiac failure — Duration

Due to Hypertension & dis.

Due to

Other Conditions Carcinoma over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Akman M. D.
Address Sinai Hosp Date signed 3/5/44

VS 150

G 14769

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14769 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Oakland St
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 Runton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nanny Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sadie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day hr.	min.
43				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-44 (month) (day) (year)
(c) Cemetery or Crematory Herrgott Rem
Location Philad Rd & Belvidere Ave
18 (a) Funeral director Jack Lewis
(b) Address 1439 E. Balto St
19 (a) (Date rec'd by registrar) MAR 6 - 1944 (b) Huntington Hill Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 44 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 19 44 to 3-5 19 44.
and that I last saw h alive on 3-5 19 44.

Immediate cause of death: Cerebral hemorrhage
Due to Hypertension
Due to Senility

Duration

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ruth Baldwin
Address West Baltimore General Hospital Date signed 3-5-44 M.D.

G 14770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 14770 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Juneau Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Juneau Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian C. Mehr

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George Mehr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1861

8. AGE: Years	Months	Days	If less than one day
82	7	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles Henkel
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Susanna Biddison
15. Birthplace Balto. Md.

16 (a) Informant Miss Mary A. Mehr
(b) Address 3207 Juneau Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director Philip Stewart Sons
(b) Address 2024 Orleans St.

19 (a) (Date received by local registrar) (b) Filing for Williams, Registrar

MAR 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3rd 1944 at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 to 3-3 1944.
and that I last saw her alive on 3-2 1944.

Immediate cause of death
Acute Myocarditis (Sudden heart failure) — Duration 2 days
Due to Arterial Hypertension — 10 years
Due to Chronic Nephritis — 10 years
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4518 Harford Rd Date signed 3-4-44

G 14771

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 830

G 14771 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 Guilford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORINE DILLON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4 1890

8. AGE: Years 54 | Months 1 | Days 28 | If less than one day hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward J. Dillon
13. Birthplace Baltimore

MOTHER 14. Maiden Name Margaret Johnston
15. Birthplace England

16 (a) Informant Edith M Dillon (Sister)
(b) Address 2605 Guilford Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 7 44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ CATHEDRAL CEM.
Location BALTIMORE, MD.

18 (a) Funeral director FLYNN & FLEMING
(b) Address 1428 E. Lexington St.

19 (a) MAR 6 - 1944 (Date rec'd by registrar) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944, at 3 a M

21. I certify that I took charge of the remains described above, held an ~~inquiry~~ Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Attending Medical Examiner
Date signed 3-2-44

VS 151

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 1.4772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 1.4772 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 W. York St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SOLOMON RICKS

3 (b) If veteran, name war: World war #1
3 (c) Social Security Account No. 218-07-9121

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife: Gracie Ricks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace: Va (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business

FATHER
12. Name: George D. Ricks
13. Birthplace: Va

MOTHER
14. Maiden Name: Roberta —
15. Birthplace: Va

16 (a) Informant: Gracie Ricks
(b) Address: 6 W. York St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 8-44 (month) (day) (year)
(c) Cemetery or crematory: National Cem
Location:

18 (a) Funeral director: James A. Hayes
(b) Address: 142 W. Fell St

19 (a) MAR 6 - 1944 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944, at 1 25 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Attending Medical Examiner.
Date signed 3-4-44

VS 151

Correct age in carefully important. Typewrite, if possible, print with ink. Spell out words. Do not use abbreviations. Answer each question. If none, write none. Give the cause of death clearly and legibly.

G 14773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G 14773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 560 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
33 3 2			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name Henderson Jones
13. Birthplace md

MOTHER
14. Maiden Name Ella Jones
15. Birthplace md.

16 (a) Informant Ella Davis
(b) Address md

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 7 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by reg. dist.) (b) Registrar

MAR 6 1944

Hunter & for Howard, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3 19 44 at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 19 44 to 3-3 19 44 and that I last saw h[illegible] alive on 3-3 19 44.

Immediate cause of death Lobar Pneumonia (a) — Duration 6 days

Due to

Due to

Other Conditions Shock. Hypertension C-V-D.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Jones Jr. M. D.
Address 3-7-44 Date signed 3-5-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

83a

14774

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Argyle Ave St. Ward 17

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Louisa Newman

If U.S. Veteran specify WAR

(a) Residence: No. 1104 Argyle Ave. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	Col	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76 75			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME Newman

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Brown

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Calvary Date Mar. 7 1944

19. UNDERTAKER Adolphus Halstead

(Address) 912 Edmondson Ave

20. MAR 6 - 1944 19 ... Registrar.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Mar. 2 1944

22. I HEREBY CERTIFY, That I attended deceased from Feb. 29 1944 to Mar. 2 1944

I last saw h[illegible] alive on Mar 2 1944 Death is said to have occurred on the date stated above, at 9.30 P.M.

The principal cause of death and related causes of importance were as follows:

Hemorrhage Brain.

Date of onset

Other contributory causes of importance:

Was an operation performed? ... Date of ...

For what disease or injury? ...

What test confirmed diagnosis? ... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Frank Elvagnus M. D.

(Address) 2027 Fearrit

G 14775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14775 Registered No. 108

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 647 Paca St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 647 Paca St (If rural give location)
(e) Citizen of foreign country? N. (Yes or No)
If yes, name country

3 (a) FULL NAME Rufus Jefferson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
53 y. 5m			hr. min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation Labour
11. Industry or business Fairfield Shipyard

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant Mrs Maude Jefferson
(b) Address 647 Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Lunderland
Location

18 (a) Funeral director Adolphus Hilstad
(b) Address 918 Druid Hill Ave

19 (a) MAR 6 (Date rec'd by registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 4 1947 at 2 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1947 to Mar 4 1947 and that I last saw him alive on Mar 4 1947.

Immediate cause of death Lobar Pneumonia — Duration 14 days

Due to

Due to None

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H.C. Pelletier M. D.
Address 317 Hamilton Terr. Date signed

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14776 46F

✓ G 14776 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3512 Fleet st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Fleet Ste (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Masson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles Masson 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1895

8. AGE: Years 48 | Months 4 | Days 9 | If less than one day hr. 15 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Molty
13. Birthplace Balto.

MOTHER 14. Maiden Name Sara Barwick
15. Birthplace Balto.

16 (a) Informant Charles Masson
(b) Address 3512 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director John O'Connelly
(b) Address 418 Eastern Ave. Steel Hearse

19 (a) Hearse (Date rec'd by registrar) Registrar

MAR 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to March 3 1944 and that I last saw h[illegible] alive on March 6 1944

Immediate cause of death Carcinoma of Biliary Tract + Liver

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Tumavosky M. D.

Address 2479 Eastern Ave Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TO #35104 G 14777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. G 14777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 764 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Mary Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grafton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1906

8. AGE: Years 37 | Months 9 | Days 6 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Jacob Stewart
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Louisa Spencer
15. Birthplace: Md.

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 6-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn Cem.
Location

18 (a) Funeral director: Mrs. Hattie R. Williams
(b) Address: 322 N. Lakewood St.

19 (a) (Date received by registrar) (b) Registrar

MAR 6 - 1944

Hunting for Relatives, Etc.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1944, at 2:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1943. to 3-2 1944.
and that I last saw h[illegible] alive on 3/2 1944.

Immediate cause of death: Ca of Breast
Metastasis

Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible] above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Paul Mattes M. D.
Address: B. C. H. Date signed: 3/2/44

G 14778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 14778971

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 Stricker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Stewart

3 (b) If veteran, name war No

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1943

8. AGE: Years	Months	Days	If less than one day
1	1	21	23 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Mack Stewart
13. Birthplace Winsboro S.C.

MOTHER
14. Maiden Name Azalea Jenkins
15. Birthplace Winsboro S.C.

16 (a) Informant Azalea Jenkins
(b) Address 1019 Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7, 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) MAR 6 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5-1944 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4-1944 to 3-5-1944. and that I last saw him alive on 3-4-1944.

Immediate cause of death	Duration
Bronchopneumonia	2 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank D. Saunders M. D.
Address 1029 N. Stricker St. Date signed 3-5-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 14779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thurman Teal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18-1911

8. AGE: Years 32 | Months 4 | Days 14 15 | If less than one day hr min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Oscar Teal
13. Birthplace N.C.

MOTHER
14. Maiden Name Della Moore
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) MAR 6 - 1944 (Date filed by registrar) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1944, at 7.35 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/26 1944 to 3/3 1944, and that I last saw h[illegible] alive on 3/3 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address B. C. H. Date signed 3/4/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14780 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 St. Ambrose St. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Armando LANCIOTTI

Armando Lanciotti

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-01-8432

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: ANTONIETTA LANCIOTTI

ANTONIETTA 6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 9-24-94

8. AGE: Years 49 | Months 5 | Days 10 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

MOTHER | 12. Name Pasquale LANCIOTTI

FATHER | 13. Birthplace Italy

MOTHER | 14. Maiden Name Fedele De ANGELIS

15. Birthplace Italy

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH-8 (month) (day) 1944

(c) Cemetery or crematory Farkwood

Location Taylor Ave

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Morley St.

19 (a) MAR 9 1944 (b)

(Date received by registrar)

Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944, at 12 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1944 to Mar. 5 1944 and that I last saw him alive on Mar. 5 1944.

Immediate cause of death: Heart failure

Due to: pneumonia & pneumonitis

Due to: Ca lung

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca lung pneumonitis

or autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Burch M.D.
Address Johns Hopkins Hosp. Date signed 3-5-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

G 14781

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 ds.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SAM WILLIAM PATTISON

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 217-16-4891

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife: Mary Pamelia Broughten

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1856

8. AGE: Years	Months	Days	If less than one day
87	3	4	hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Auctioneer

11. Industry or business

FATHER
12. Name Thomas Pattison
13. Birthplace Dorchester County, Md.

MOTHER
14. Maiden Name Elizabeth Marlton
15. Birthplace Maryland

16 (a) Informant Mrs. Herbert Crisp
(b) Address 2709 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.
Location Baltimore County, Md.

18 (a) Funeral director HENRY SANDER & SONS, Inc.
(b) Address North Ave. & Broadway

19 (a) ____ (b) ____
(Date received by registrar) Registrar

MAR 6 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 10 44/A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1944, to 3-2 1944, and that I last saw him alive on 3-2 1944.

Immediate cause of death: Cardio-respiratory failure

Due to: Chronic nephritis

Due to: Generalized arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ____ M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Muegatunga Jr. M. D.
Address 332 W. University Pkwy Date signed 3/2/44

G 14782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14782 Registered No. 92 D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6806 Fait ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) All May

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6806 Fait ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ignatius Dabkowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Frances Dinka | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Martin Dabkowski
13. Birthplace Poland

MOTHER 14. Maiden Name Anna ?
15. Birthplace Poland

16 (a) Informant Jas Anthony Dabkowski
(b) Address 4414 S Duncan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Wilms
(b) Address 401 N. Charles Street

19 (a) (Date rec'd by registrar) (b) No. 92 Waiting for Medical Certification

MAR 6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1944, at 6:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 25 1943 to March 2 1944, and that I last saw h[illegible] alive on March 2 1944.

Immediate cause of death: Cardiac Failure — Duration

Due to Arteriosclerosis (Senile) Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 925 E Eutaw St Date signed

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 14783
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 Pennington Ave.
(c) Hospital or institution: ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 54yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Pennington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel S. Reproth.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married (Husband)

6 (b) Name of husband or wife Emma E. Reproth
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) March 22, 1862

8. AGE: Years	Months	Days	If less than one day
81	11	14	hr. min.

9. Birthplace York Co Pa. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Freight Conductor Penna R.R.

FATHER
12. Name William Reproth
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Matilda ?
15. Birthplace Pennsylvania

16 (a) Informant Emma E. Reproth
(b) Address 3030 Pennington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge.
Location

18 (a) Funeral director Edmonds Bros Inc.
(b) Address 3615-17 Edmondson Ave

19 (a) MAR 6 - 1944 (Date Rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5, 1944 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 3, 1944 to Mar 5, 1944, and that I last saw him alive on Mar. 4, 1944

Immediate cause of death: Coronary Thrombosis — Duration
Due to: Coronary Artery Disease
Due to: Hypertension
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Glassman M.D.
Address 403 Tollis Rd. Date signed 4/5/44

Please write plainly, with unfading ink. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

24784

BRENGLE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G 14784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 N. Fanny St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N. Fanny St (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Naomi V. Brengle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William C. Brengle

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) June 13, 1880

8. AGE: Years 64 | Months 1 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name George W. Bandel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Loy
15. Birthplace Washington Co., Md.

16 (a) Informant Mrs. William C. Brengle
(b) Address 916 N. Fanny St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt. View
Location West Friendship, Md

18 (a) Funeral director Frederick R. Lee
(b) Address 1200 W. Lombard St

MAR 6 - 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1944 at 10½ PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1944 to March 2, 1944; that I last saw her alive on March 2, 1944.

Immediate cause of death: Carcinoma of Left Breast, Metastatic Carcinoma of Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1942

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel D. Wolfe M. D.

Address 1331 S. Kouth Ave Date signed 3-4-44

Physicians: Please write the causes of death clearly and legibly. Report age in especially important. Physicians: please write the causes of death clearly and legibly.

G 14785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14785

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3807 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? If yes, name country (Yes or No)

3 (a) FULL NAME Mrs. George [redacted] Beaty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife Thomas Beaty
nee Kohler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-29-1872

8. AGE: Years	Months	Days	If less than one day
71	6	5	hr. min.

9. Birthplace retired Bricklayer
10. Usual Occupation (Town, county, and state) Baltimore, Md
11. Industry or business

FATHER
12. Name John Beaty
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Stevens
15. Birthplace Md.

16 (a) Informant Mrs. Carolina Schmidt
(b) Address 3807 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) (b)

MAR 6 1944 [illegible] Registrar

correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944, at 11 A.M. 40

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1944 to Mar 3 1944 and that I last saw h[illegible] alive on Mar 3 1944.

Immediate cause of death Congestive heart failure & pulmonary edema. — Duration

Due to Chronic pulmonary disease.

Due to Asthma

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? at M (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Thomas Brennan M. D.
Address St. Joseph Hospital Date signed 3-5-44

4498314786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 14786
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Durham (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Thornton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-43

8. AGE: Years	Months	Days	If less than one day
	7	1	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name George Thornton
13. Birthplace N.C.
14. Maiden Name Elsie Jones
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) MAR 6 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944, at 8 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1944 to Mch 3 1944, and that I last saw her alive on Mch 3 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Bilateral Pneumonic Consolidation	
Due to Tuberculosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kay M.D.
Address JHH Date signed 3/5/44

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

89a

G 14787 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 S. Durham Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. Durham Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Lee Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 30 - 1940

8. AGE: Years	Months	Days	If less than one day
3	5	5	hr. min.

9. Birthplace Bo Remove Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Alfred T. Martin
13. Birthplace Ba Co. Md.

MOTHER
14. Maiden Name Eleanor Price
15. Birthplace Ba Co. Md.

16 (a) Informant Eleanor Price Martin
(b) Address 20 S Durham St.

17 (a) Burial (b) Date thereof 3/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory H. R. Dorsey Cem.
Location Belair Rd.

18 (a) Funeral director M. W. E. Dysart Sons
(b) Address Lombard & Bond Sts

19 (a) MAR 7 1944 (b) Hunting for Williams
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5- 1944, at 8 45 AM

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Suppurative Otitis Media

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Welsh M.D.
Medical Examiner.
Date signed 3-6-44

14788

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH / 106 C

G 14788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3621 Hamble Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 / 17
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Edgemere, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Earles Beach Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie R. Earle

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Wm G. Earle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20th 1870

8. AGE: Years	Months	Days	If less than one day
73	4	14	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John A. Edwards
FATHER 13. Birthplace England

MOTHER 14. Maiden Name Eliz. Biddison
MOTHER 15. Birthplace Balto. Co. Md.

16 (a) Informant W. L. Earle
(b) Address Edgemere Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) (day) (year)
(c) Cemetery or crematory Evergreen Meth
Location Balto. Co. Md.

18 (a) Funeral director Loudon Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Mar 6 1944 (Date rec'd by local registrar) (b) [illegible] (Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944 at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Feb 1944 to 4 Mar 1944 and that I last saw h[illegible] alive on 4 Mar 1944.

Immediate cause of death Lung abscess — Duration 1 yr.
Due to Bronchiectasis — 5 yrs.
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Z. Wayne Hooper M. D.
Address 358 Ellerslie Date signed 4 March 44

14789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 14789

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline

(c) Hospital or institution: St. Josephs Hospital

(d) Length of stay in hospital or inst. ~~yrs. mos.~~, or days 6 9 9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Fullerton (If outside city or town limits, write RURAL and give town)

(d) Street No. Hunts Road (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country

3 (a) FULL NAME Jennie Lusikorn (MARY V. LUSIKORN)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frank J. Lusikorn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	6	28		

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Thomas Simms

13. Birthplace Balto. Co. Md.

MOTHER

14. Maiden Name Cordelia Burton

15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. John Simms

(b) Address Meadow Ave. Fullerton Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar. 7, 1944 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto. Md.

18 (a) Funeral director Loveless Funeral Home

(b) Address 7401 Belair Road

19 (a) Mar 1944 Huntington Williams Registrar

(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 4 1944 at 11 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1944 to Mar. 4 1944 and that I last saw h e i alive on March. 4 1944.

Immediate cause of death Cerebro-Vascular Accident

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas Bowman M.D.

Address St Joseph Hospital Date signed 3-7-44

Record age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14790

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14790 Registered No. 106 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Garrison avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Garrison avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No).
If yes, name country

3 (a) FULL NAME M. KATHARINE HOOPER

3 (b) If veteran, name war ***
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1854 ?

8. AGE: Years 90 ? | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Thomas H. Hooper, Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Young
15. Birthplace Baltimore

16 (a) Informant Thomas V. Hooper
(b) Address 2300 Mt. Royal Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) (b) Registrar
1944 (Date rec'd by registrar)
Via Ibo Huntington Pittsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 / 1943. to 3 : 3 1944, and that I last saw h[illegible] alive on 3 - 3 19 44.

Immediate cause of death: Arterio sclerosis, hypertension
Due to: Chr. Bronchitis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature H. Edmunds Keirn
Address 3400 Hilton Rd Date signed 3/4/44

G 14791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 14791 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Information must be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 3 day
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, limits write RURAL and give town)
(d) Street No. 1113 Watson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hezikiah Leach
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Mar.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 52 | Months 2 | Days — | If less than one day hr. min.

9. Birthplace Concord N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Lawson Leach
13. Birthplace Concord N.C.

MOTHER
14. Maiden Name Caroline 2.
15. Birthplace N.C.

16 (a) Informant Mary Betts. Nephew
(b) Address 269 Broadway Apt
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn. Md. Co.
18 (a) Funeral director Mrs Lydia Bailey
(b) Address 1421 Jefferson St.
19 (a) (Date rec'd by registrar) (b) Registrar

MAR 8 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2-1944, at 8 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1944, to Mar 2 1944, and that I last saw her alive on Mar. 2 1944.

Immediate cause of death: Cerebral Hemorrhage
Due to
Due to Essential Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Williams M.D.
Address Provident Hospital Date signed 3/4/44

G 14792

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 14792 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 Hawthorne Rd.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Hawthorne Rd (If rural give location)
(e) Citizen of foreign country? -No- (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Broughton Beacham

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No.: none
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rena S. Beacham
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.): Dec-14-1893
8. AGE: Years 50 | Months 2 | Days 19 | If less than one day: hr. 20 min.
9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Civil Engineer
11. Industry or business: City of Balto.

FATHER
12. Name: Fredk. B. Beacham
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Emily Broughton
15. Birthplace: Norfolk Va

16 (a) Informant: Mrs Rena S. Beacham (wife)
(b) Address: 500 Hawthorne Rd
17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3-6-44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore
18 (a) Funeral director: Stuart Mann Co.
(b) Address: 108 W Mt Royal Ave. Thru Lucy for Williams
19 (a) MAR 6 - 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944 at 2 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to 3/4 1944 and that I last saw h alive on 3/4 1944.

Immediate cause of death: Coronary Thrombosis — Duration 12-15 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W A Reedy
Address 1403 Park Ave Date signed 3/6/44

VS 150

G 14793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14793 Registered No. 49a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 126 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Chaptank Court (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ettie King

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Gilbert King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1894

8. AGE: Years	Months	Days	If less than one day: hr.	min.
49	6	20	22	

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housf.
11. Industry or business

FATHER
12. Name Thomas Dunn
13. Birthplace Nor. Carolina

MOTHER
14. Maiden Name Eliz. Flannigan
15. Birthplace Nor. Carolina

16 (a) Informant Hospital Records
(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory Lawson Cem.
Location Leakville N. C.

18 (a) Funeral director Lilly and Gilmine
(b) Address 403 S. Wolfe St

MAR 6 – 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5 1944, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1944, to 3/5 1944, and that I last saw h[illegible] alive on 3/5 1944.

Immediate cause of death Cardio resp. failure — Duration

Due to Generalized carcinoma to sig — Duration

Due to Bilat. ovarian dermoid cysts c malig. degen. — Duration: at least 3 mos.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Jan 7, 1944
Major findings of operation: Bilat ovar. tumors c metastases.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. N. Crosby
Address Mercy Hosp. Date signed 3/5/44

VS 150

G 14734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14794 / 940

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 S.CLINTON ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 11
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 S.CLINTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DENIS P.LARDNER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 213-07-7374

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARTHA LARDNER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV.8 1895

8. AGE: Years	Months	Days	If less than one day
48	3	25	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation CHEMIST
11. Industry or business BETH.STEEL CO.

FATHER
12. Name JOHN LARDNER
13. Birthplace IRELAND

MOTHER
14. Maiden Name CATHERINE CRINE
15. Birthplace IRELAND

16 (a) Informant MARTHA LARDNER(WIFE)
(b) Address 708 S.CLINTON ST.

17 (a) BURIAL (b) Date thereof MAR.7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD

18 (a) Funeral director Lilly and Zeiler / N.C. Williams
(b) Address 403 S.POLE ST. Hunting

19 (a) (b)
(Date received by Registrar) Registrar
MAR 6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR.3 1944 at 3/05 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19.43 to March 3 19.44 and that I last saw h alive on 2/3 1944.

Immediate cause of death	Duration
Due to Bronchopneumonia, heart weakness, repeated coronary thrombosis	8 Mths 2 Wks
Due to	
Other Conditions Arteriosclerosis with hypertension. (Include pregnancy within 3 months of death)	7

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Damian P. Alegra M. D.
Address 33 Hopkins Place Date signed
Balto Md

G 14735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G 14795 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital - Balto Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2540 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Seaborn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 14, 1890

8. AGE: Years 54 | Months - | Days 20 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Joseph Morz.
13. Birthplace Poland.

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant: Norma Lackewich
(b) Address 2540 Fleet St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location German Hill Rd.

18 (a) Funeral director Marie E. Fralhowrth
(b) Address 1500 S. Kenwood Ave

19 (a) [illegible] (b) [illegible] Registrar

(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944, at 4:05 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Thrombocytopenic Purpura Hemorrhagica

Due to

Other Conditions Hypertensive Cardiovascular disease Syphilis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chas. F. Sullivan M.D. Medical Examiner.
Date signed 3/7/44

correct age is apparently inconsistent

14796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 14796
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr 39 min
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 St Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Strauf

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1944

8. AGE: Years	Months	Days	If less than one day
—	—	—	1 hr. 39 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation baby
11. Industry or business

FATHER
12. Name A. Ward Hammul
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mabel Strauff
15. Birthplace Baltimore, Md

16 (a) Informant Mabel Strauff
(b) Address Baltimore Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) MAR 6 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1944 at 8 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1944, to Feb 29 1944, and that I last saw him alive on Feb 29 1944

Immediate cause of death	Duration
Congenital atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Le Roy W. Tilt Jr. M. D.
Address University Hospital Baltimore, Md. Date signed 2/29/44

VS 3

0768

14797

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 159

G 14797
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Lombardy Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy #2 Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			8 hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Cudy Brooks
13. Birthplace Va

MOTHER 14. Maiden Name Nina Gobett
15. Birthplace W Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 Filed by registrar MAR 6 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1944 at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 ,
and that I last saw him alive on Feb. 22 19 44.

Immediate cause of death Respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Kaufman
Address JHH Date signed 3-7-44

0769

14798

Spec.—1-17-36—A Co.—300 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 14798

CERTIFICATE OF DEATH

159

REGISTERED NO.

1-PLACE OF DEATH 1340 S. Charles St.

City of BALTIMORE: (No. Dr. Francis Priv. Hospital Ward) 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Everhart

(a) RESIDENCE NO. 13 Palapsco Ave. St. Ward Anne Arundel

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Baby

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 3. 44

7 AGE Years Months Days: 1 1/2 2

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Everhart

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Cleveland Ohio.

12 MAIDEN NAME OF MOTHER Dixie Riggs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Uniontown Pa.

14 Informant
(Address)

MAR 6 1944 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5th 1944

17 I HEREBY CERTIFY, That I attended deceased from March 3 1944 to March 5 1944

that I last saw him alive on March 5 1944

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Aspiration Atelectasis

Prematurity.

(duration) yrs. mos. 2 da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Chas. L. Ball Jr. M. D.

. 19 (Address) Linthicum, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHN HOPKINS MEDICAL SCHOOL

Date of Burial MAR 6 1944

20 UNDERTAKER Commissioner of Health ADDRESS

0770

OF DEATH is plain legible, no case is any be properly completed. Many important. See instructions on back of certificate.

443726 14799 BALTIMORE CITY HEALTH DEPARTMENT X G 14799 Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Pr. Geos
City or town Greenbelt (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 K Hillside Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Klinenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-17-31

8. AGE: Years	Months	Days	If less than one day hr.	min.
12	8	18	19	

9. Birthplace Chicago Ill. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles S. Klinenberg
13. Birthplace Chicago Ill.

MOTHER
14. Maiden Name Bernice Fried
15. Birthplace Chicago Ill.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

Removal & Burial Date thereof 3/6/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Chicago Ill
18 (a) Funeral director Harry Goodman & Son
(b) Address 1902 Eutaw Place, Balto, Md
19 (a) (b) Huntington Pallbearers, Md
(Date rec'd by registrar) Registrar

MAR 6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR - 6 1944 at 345 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1943 to MAR 6 1944 and that I last saw him alive on MAR 6 1944.

Immediate cause of death: Cerebral hemmorrhage
Pneumonia
Due to Periarthritis nodosa
Due to see infection
Other Conditions Periarthritis nodosa
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: yes

Duration: Nov 29 to March 6 1944

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Jones
Address Johns Hopkins Hosp Date signed 3/6/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14800 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 608 Somerset Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Vernon F. Kelly

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Fauna Spangler Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1883

8. AGE: Years 60 | Months 9 | Days 23 | If less than one day hr. — min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Charles Eugene Kelly
13. Birthplace Maryland

MOTHER
14. Maiden Name ~~Matilda~~ Martha Proctor
15. Birthplace Maryland

16 (a) Informant Mrs. Fauna S. Kelly
(b) Address ~~JOHNS HOPKINS HOSP~~ 608 Somerset Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8, 1944 (month) (day) (year)
(c) Cemetery or Crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Bryagg Funeral Home
(b) Address 3631 Falls Road

19 (a) MAR 6 - 1944 (b) Registrar
Received by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 5 1944 to Mar. 5 1944 and that I last saw him alive on Mar. 5 1944.

Immediate cause of death Coronary Occlusion — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Speed M.D.
Address John Hopkins Hospital Date signed 3-5-44

VS 150

SPEED

JO #86276 G 14801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 14801 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 4 da.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1608 Barclay St. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Whitely (Maggie E. Whiteley)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband William Henry

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1873

8. AGE: Years 70 | Months 6 | Days 18 | If less than one day: hr min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed Housewife

11. Industry or business

FATHER 12. Name Jonathan Biggs (d)

13. Birthplace Maryland

MOTHER 14. Maiden Name Hannah Bordley (d)

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/44 (month) (day) (year)

(c) Cemetery or crematory St Mary's Hampden

Location Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) Date rec'd by registrar MAR 6 1944 (b) Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1944, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1944 to 3-5 1944, and that I last saw h alive on 3-5 1944.

Immediate cause of death: Edema — Diabetic Gangrene Both Legs — Duration: 2 mo

Due to: Diabetes Mellitus — Duration: 15 yrs

Due to: Hypertensive C. V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-4-44

Major findings of operation: Gangrene both legs

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald B Hebb

Address Balto City Hosp Date signed 3-5-44 M. D.

G 14802

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 35

G 14802
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 E. Chase St.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Frances Burke

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Colored

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1943

8. AGE: Years	Months	Days	If less than one day
1	0	2022	hr. min

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Patrick Burke
13. Birthplace England

MOTHER
14. Maiden Name Delia Scully
15. Birthplace Ireland

16 (a) Informant Mrs Delia Burke
(b) Address 1010 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 7/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Hoffman Rd at Broadway

18 (a) Funeral director Elmer W. Confalonieri Sons
(b) Address 924 Eagle St.

MAR 6 - 1944
(Date rec'd by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5th, 1944, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 3 1944. to Mar 5 1944. and that I last saw h/M alive on Mar 3 1944.

Immediate cause of death Bronchio-Pneumonia — Duration 2 days

Due to —

Due to —

Other Conditions Measles — 1 week

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Joseph N. Blum M.D.
Address 1206 E. Preston St. Date signed 3/6/44

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G 14803 Registered No.

Caution: Age as especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give location)
(d) Street No. 1025 Greenmount Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Aloysius McDonald

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Nellie McDonald
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Jan. 14 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	1	20	8	

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business City of Balto

FATHER
12. Name Thos. McDonald
13. Birthplace Ireland

MOTHER
14. Maiden Name Rosan Ward
15. Birthplace Baltimore

16 (a) Informant Mrs Helen Rourke
(b) Address 1025 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Hartford Rd & Broadway

18 (a) Funeral director Edward J. Cahill & Co.
(b) Address 924 E. Baltimore

19 (a) MAR 6 - 1944 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6 1944 at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1942 to Mar 5 1944, and that I last saw him alive on Mar 5 1944.

Immediate cause of death
Acute myocardial failure
Due to Myocarditis
Related Heart
Due to Chronic Bronchitis
Bronchial Asthma

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration
2 yrs.
20 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Mac Murchy M.D.
Address 709 E. Chase St Date signed 3/10/44

Transit for Baltimore

14804

JO #33614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. C 14804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yr. 9mo. 4days.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Friendly Inn, Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1877

8. AGE: Years	Months	Days	If less than one day
66	5	27	hr. min.

9. Birthplace California (Town, county, and state)
10. Usual Occupation Fruit Picker
11. Industry or business

FATHER
12. Name Levin Davis
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Hudson
15. Birthplace California

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 6 1944 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1944, at 8:10PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/41 1938, to 2/28 1944.
and that I last saw h[illegible] alive on 2/28 1944

Immediate cause of death: Bronchopneumonia — Duration: ?
Due to: Cerebral thrombosis — Duration: ?
Due to: [illegible] with Leukemia
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mabe
Address B. C. L. Date signed 3/2/44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0573

14805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14805

Registered No. 1147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fonerbank + Green Sts
(c) Hospital or institution: Maternity Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Vienna
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Hayward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jim Hayward

13. Birthplace Md.

MOTHER 14. Maiden Name Tessie Holmes

15. Birthplace Md.

16 (a) Informant Self.

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAR 6 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1944 at 9:A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1944 to Feb 26 1944, and that I last saw him alive on Feb 27 1944.

Immediate cause of death	Duration
Multiple Abscess	
Due to Lung Abscess.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Multiple Abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan B. Jaworski

Address University Hosp. Date signed 3/3/44 M. D.

VS 3

0.72

Cover age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14806 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4413 Old York Rd.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Austria

3 (a) FULL NAME Mrs. Elizabeth Forst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Hermann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6-1862

8. AGE: Years	Months	Days	If less than one day
81	8	29	hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Mencsorzky

13. Birthplace Hungary, austria

MOTHER 14. Maiden Name Dont

15. Birthplace Austria

16 (a) Informant Bro. Mullen

(b) Address 530 Ralpho

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/44 (Month) (day) (Year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Co. Md.

18 (a) Funeral director John J. Hogan

(b) Address 3000 E. Baltimore St.

19. 3-8-1944 Huntington Williams, Registrar
(Date filed) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1944 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944 to 3/5 1944 and that I last saw her alive on 3/5 1944.

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to

Due to

Other Conditions Hypertension Cardio-Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Konz

Address 530 Ralpho Ave Date signed 3-8-44

VS 3

14807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. C 14807

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 S. Washington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 S Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Staniewicz

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helen Staniewicz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Anthony Staniewicz
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant Helen Staniewicz
(b) Address 502 S. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 8/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) MAR 7 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944, at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1943, to Mar 5 1944, and that I last saw h[illegible] alive on March 1944.

Immediate cause of death: Hypostatic Pulmonary Oedema Dec 3 — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abram L. Blechman M. D.
Address 3503 Park Ave Date signed

ABRAHAM BLECHMAN

14808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G 14808 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ineal Lanier Powell

3 (b) If veteran, name war

3 (c) Social Security Account No. 223-16-6535

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Margaret Powell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 - 1920

8. AGE: Years 23 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethelhem Steel

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Bettie Barber
15. Birthplace Va

16 (a) Informant Margaret Powell
(b) Address 1606 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 9-44 (month) (day) (year)
(c) Cemetery or crematory Forest Hill
Location Lynchburg Va

18 (a) Funeral director Sam'l N Chase & Son
(b) Address 638 N. Gilmor St

MAR 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 5 1944, at 8:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

P.

(a) Date of injury March 5 1944 8:30 A.M.
(b) Where did injury occur? Bond & Lombard Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Shot

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed March 6, 1944

G 14809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G 14809 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3021 Lock Raven Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) G
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town) M
(d) Street No. 3021 Lock Raven Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Peacock

3 (b) If veteran, name war Spanish-American | 3 (c) Social Security Account No. 216-03-4813

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mamie A. Peacock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10th 1879

8. AGE: Years	Months	Days	If less than one day
64	4	24	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Mattress Finisher
11. Industry or business Heller Co

FATHER
12. Name William Peacock
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Naylor
15. Birthplace Washington D.C.

16 (a) Informant Mamie A. Peacock
(b) Address 3021 Lock Raven Blvd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/8/44 (month) (day) (year)
(c) ~~Cemetery or crematory~~ National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 14 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4th 1944 at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15th 1944 to Mar. 4th 1944.
and that I last saw him alive on Mar. 4th 1944.

Immediate cause of death: Coronary Embolism — Duration: about 9 hrs.
Due to: Endocarditis — unknown
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Montgomery M.D.
Address 401 E. 25th. St. Date signed 3/6/44.

G 14810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G 14810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1532 Northgate Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Northgate Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Liddie J Houck

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George W Houck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1872

8. AGE: Years 71 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Hampton Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name David C Strasburg
13. Birthplace Va

MOTHER 14. Maiden Name Emma J Kite
15. Birthplace Va

16 (a) Informant Mrs L Lite
(b) Address 1532 Northgate Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Location Pikesville Md

18 (a) Funeral director Wilbur Cook Inc
(b) Address 1217 St Paul St Phone Hunting Ton Mulberry

19 (a) MAR 7 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to March 1944. and that I last saw h alive on March 3 1944.

Immediate cause of death cerebral thrombosis — Duration 1 week
Due to arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Everett H Morton Jr M. D.
Address 2706 St Paul St Date signed 3/6/44

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 14811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 14811 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastland & Greene Sts
(c) Hospital or institution: University Hospital, Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 E. Lanvale St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Nelson Logan

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 21 62

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 13th 1888

8. AGE: Years	Months	Days	If less than one day
55	3	21	hr. min.

9. Birthplace Newark N. J.
10. Usual Occupation Doctors Office
11. Industry or business Dr. A. E. MacGowan

FATHER
12. Name John Logan
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Shonk
15. Birthplace Md.

16 (a) Informant Elizabeth Logan Oakwood
(b) Address Shepherd Apt. East Orange N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 7 - 1944 Hunting for Williams M.E

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944 at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1944 to P. M. 1944 and that I last saw him alive on March 4 1944.

Immediate cause of death	Duration
Carcinomatosis abdomin - primary site undetermined	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Logan, M.D.
Address University Hospital Date signed 3-6-44

G 14812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 14812 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Wagsmith St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Wagsmith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L Framer

3 (b) If veteran, name war W
3 (c) Social Security Account No. 216-09-4676

4 Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6, 1896

8. AGE: Years 47 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Hgt Finisher
11. Industry or business Auto Mfg Co

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Theodore E. Kipp
(b) Address 1215 E Oliver St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 3/8/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Williams Lodge Inc
(b) Address 1217 N Carey St

19 (a) MAR 7 1944 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to March 5 1944 and that I last saw him alive on 3-5 1944

Immediate cause of death: myocardosis — Duration:

Due to chronic endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J Gould M. D.
Address 14 N East ave Date signed 3-6-44

VS 180

G 14813

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 ✓ G 14813 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto., Md
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Thames St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK SADOWSKI

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
JOHN HOPKINS MEDICAL SCHOOL MAR 6 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) MAR 6 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11th 1944, at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 2-12-44

0117

G 14814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G 14814 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 Forrest St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) — 5
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 337 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Jerome Sumnit

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife ✓

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years 80 | Months ✓ | Days — | If less than one day ✓ hr. ✓ min.

9. Birthplace ✓ (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business ✓

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant C. I. O.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address Hunting Ton Indiana

19 MAR 6 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 19 44, at 2 55 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h/2 death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Clinton L. Colbert M.D. Medical Examiner.
Date signed 3/2/44

0776

14815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93a

G 14815
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Vine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1862

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) MAR 6 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15 1927, at 4.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Myocarditis
Pulmonary Edema
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature Martin L. Lawrason M.D.
Medical Examiner.
Date signed 7/15/27.

0775

816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

✓ G 14816

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 927 E. Madison St. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Major Pittman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
26			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 6 1944 Huntington Williams M.D.
(Date rec'd by registrar)

0774

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1944, at 9:30 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 22, 1944 9:15 P. M.
(b) Where did injury occur In front of 927 E. Madison St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Stab wound of throat

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb. 23, 1944

G 14817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 106c

G 14817 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Pearl St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Patricia Dianne Ball

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1943

8. AGE: Years	Months	Days	If less than one day
	2	21	hr min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name George Edward Ball
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Ethel Cox
15. Birthplace Virginia

16 (a) Informant George E. Ball
(b) Address 18 N. Pearl St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Balto

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 7 - 1944 Huntington Md., M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1944, at 2:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1944, to 3-7 1944, and that I last saw h E C alive on 3-7 1944.

Immediate cause of death Laryngeal obstruction

Due to Laryngo-tracheo-bronchitis

Due to

Other Conditions No other Complications (Include pregnancy within 3 months of death)

Date of operation 2-12-44

Major findings of operation: Emergency tracheotomy

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Ozogowski M. D.
Address Mercy Hospital Date signed 3-7-44

G 14818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51B

G 14818 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4547 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benedict Henry Hanson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex MALE
5. Color or race White
6 (a) Single, married, widowed, or divorced. MARRIED
6 (b) Name of husband or wife Rebecca Cox Hanson
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Aug. 14, 1866
8. AGE: Years 77 Months 6 Days 18 If less than one day hr. min. 22
9. Birthplace MARYLAND (Town), county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Aquilla Brown Hanson
13. Birthplace MARYLAND

MOTHER
14. Maiden Name Ann Elizabeth Middleton
15. Birthplace MARYLAND

16 (a) Informant Admission sheet +
(b) Address Neice

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 8 1944 (month) (day) (year)
(c) Cemetery or crematory Churchville Episcopal
Location Churchville Md

18 (a) Funeral director Henry H. Jenkins Sons Co.
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 7 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 20 1944, to March 6 1944, and that I last saw h(im) alive on MARCH 5 1944.

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to Adenocarcinoma of Prostate & Metastases

Due to

Other Conditions PATHOLOGICAL FRACT. OF RT. FEMUR
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill M. D.
Address Union Memorial Hosp Date signed 3-6-44

G 14819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G 14819 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 S.Grundy St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 S.Grundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Katherine Bartholow

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry Bartholow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov,18/87

8. AGE: Years 56 | Months 3 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Balto.Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Donahue
13. Birthplace ---

MOTHER
14. Maiden Name ---
15. Birthplace ---

16 (a) Informant Mr.Harry Bartholow
(b) Address 906 S.Grundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar.10/44 (month) (day) (year)
(c) Cemetery or crematory Cath Union Cem
Location Balto.Md.

18 (a) Funeral director Philip Hennig Sons
(b) Address 2024 Orleans St.

19 (a) MAR 7 1944 (Date received by registrar) (b) Registrar

Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar.6/44 19 , at 11.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1942 to June 6 1944. and that I last saw h alive on June 5 19 44.

Immediate cause of death: Rheumatic Cardiovascular disease

Due to: Myocardial Failure — Duration: Feb 21/44

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: E A Schumacher M. D.
Address 842 S Eutaw Date signed 3-7-44

G 14820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

G 14820 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital 7 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3324 Sumter Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leo Kreiner

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1903

8. AGE: Years	Months	Days	If less than one day
40	7	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Poultry Dealer

FATHER — 12. Name Thomas Kreiner

13. Birthplace Balto., Md.

MOTHER — 14. Maiden Name Annie May Miller

15. Birthplace Balto., Md.

16 (a) Informant Mrs. Margaret F. Kreiner

(b) Address 3324 Sumter Ave., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huston Williams, M.D. Registrar

MAR 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1944 at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1944, to 3/5 1944, and that I last saw h im alive on 3/5/ 1944.

Immediate cause of death: Cardiac failure

Due to ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Murray L. Senner M. D.

Address Date signed

FL - 6614821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 14821 30C

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 6

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1515 Chappel St. (N) (If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓

If yes, name country

3 (a) FULL NAME Sophie Coppard (Sophia M. Coppard)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: George W., Sr.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1900

8. AGE: Years: 44 Months: 1 Days: 24 If less than one day: hr. min.

9. Birthplace Md. (Baltimore) (Town, county, and state)

10. Usual Occupation ? none

11. Industry or business

FATHER: 12. Name William E. Engler

13. Birthplace Md. (Carroll Co.)

MOTHER: 14. Maiden Name Annie Diven

15. Birthplace Md.

16 (a) Informant B. C. H Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) Huntington Williams Registrar

MAR 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 19 44 at 8 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 19 43 to 3/6 19 44, and that I last saw h[illegible] alive on 3/6 19 44.

Immediate cause of death: Lobar pneumonia — Duration: 4 days

Due to: Osteria-sclerotic Heart Disease

Due to:

Other Conditions C.N.S. Lues

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia Arteriosclerotic Heart

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Acton, M. D.

Address B. C. H. Date signed 3/6/44 M. D.

G 14822
JL - 314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
107

G 14822
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 - 1 - 24
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1850 ? ?

8. AGE: Years	Months	Days	If less than one day
94 ?	?	?	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business U. S. Government

FATHER
12. Name James Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Jane Grant
15. Birthplace D. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 8-1944 (month) (day) (year)
(c) Cemetery or crematory
Location Rockville Md

18 (a) Funeral director Robert F. Knowles
(b) Address Rockville Md

MAR 7 - 1944 (b) Hunter Williams
(Date rec'd by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1944, at 5:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1943 to 3/6 1944, and that I last saw him alive on 3/6 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Acton, M. D.
Address B. C. H. Date signed 3/7/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14823 Registered No. 126

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12, 1, 11 26 42
(e) Length of stay in Baltimore (yrs., mos., or days) since 1892

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1980 Alexander St.~~
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tony Plosais

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1868

8. AGE: Years	Months	Days	If less than one day
75	2	29	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business

FATHER
12. Name John
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Crestina
15. Birthplace Italy

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 8 44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd
18 (a) Funeral director J. J. Tahey & Sons
(b) Address 1318 Light St
19 (a) MAR 7 1944 Huntington, Maryland

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1944 at 11:10 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 2/28 1944.
and that I last saw ~~alive~~ on 2/28 1944.

Immediate cause of death: Pulmonary TBC. — Duration: 4 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. L. Seymour M.D.
Address BCH Date signed 3/6

14824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G 14824
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2877 Woodbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2877 Woodbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL M. WEAVER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	219-20-9740	Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1873

8. AGE: Years	Months	Days	If less than one day
71	1	28	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Sail Maker
11. Industry or business

FATHER
12. Name James Weaver
13. Birthplace Baltimore

MOTHER
14. Maiden Name ? Hergesheimer
15. Birthplace Baltimore

16 (a) Informant Mr. Frank Weaver
(b) Address 2877 Woodbrook Ave.

17 (a) Burial (b) Date thereof 3/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Registrar's signature)

MP 87 - [illegible] Washington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1944, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 19 43 to March 6 19 44 and that I last saw h[illegible] alive on March 6 19 44.

Immediate cause of death Coronary occlusion — Duration

Due to

Due to

Other Conditions Hypertension cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Wallenmeyer M. D.
Address Medical Arts Bldg. Date signed 3-6-44

G 14825 ✓ G 14825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Arlington St.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 544 Baker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Maggie Higgins

3 (b) If veteran, name war — 3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Memuan
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 5, 1890

8. AGE: Years	Months	Days	If less than one day
53	6	29	..... hr. ..... min.

9. Birthplace S. Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Lee
13. Birthplace S. C.

MOTHER
14. Maiden Name Harriett Ford
15. Birthplace S. C.

16 (a) Informant Hattie McCoy
(b) Address 544 Baker St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 7/44 (month) (day) (year)
(c) Cemetery or crematory .....
Location Bethune S. Carolina

18 (a) Funeral director Mrs Robt A. Elliott Dept
(b) Address 1129 N. Carolina St

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944 at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1944 to 3/4/1944 1944, and that I last saw her alive on 3/4/44 19.....

Immediate cause of death
Cardiac Failure 7 ?
Hemiplegia Paralysis 3 ?
Due to Hypertension 1 ?
Coronary artery Sclerosis 1 ?
Due to Pulmonary Embolism 3 ?
Agranulocytosis Fungus Infection 3 ?
Histopathological Laboratory Dr.

Other Conditions .....

(Include pregnancy within 3 months of death)
Date of operation 3/1/44
Major findings of operations Pancreas Mass, Pelvic Adhesions
Autopsy: Dissection, tumor, pelvic adhesions, thrombosis

Duration
24 hrs.
24 "
?
?
3
3
Dr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature James S. Stanley M. D.
Address Longfellow & Eutaw Date signed 3/4/1944

G 14826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 76a

Registered No. G 14826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 East 26th St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? life years

3 (a) FULL NAME Miss Catherine Marian Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years	Months	Days	If less than one day
18 17			hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Elmer Long
13. Birthplace Kentucky

MOTHER
14. Maiden Name Theresa Dwyer
15. Birthplace Kentucky

16 (a) Informant Mrs. J. Long
(b) Address 516 E 26th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 9-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location

18 (a) Funeral director Mary M Wadefield
(b) Address 501 E 32nd St

19 (a) 1944 (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1944, to 3/5 1944, and that I last saw h[illegible] alive on 3/5 1944.

Immediate cause of death Agranulocytosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Herman Williams M. D.
Address Md. Gen. Hosp. Date signed 3/5/44

Spec.—1-13-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~G 14827~~ 1930 G 14827

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Bruce ST., WARD)

2-FULL NAME Annie Powell | 6-3

(a) RESIDENCE NO. 811 N. Bruce ST., | WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Own Home Work

9 BIRTHPLACE (city or town) Richmond Va.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Powell

11 BIRTHPLACE OF FATHER (city or town) Richmond Va
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Joseph Bayne

(Address) 811-N. Bruce st

15 MAR 7 1944 Filed ....., 19 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1944

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1944, to March 6, 1944, that I last saw her alive on March 5, 1944, and that death occurred, on the date stated above, at 1:00 a.m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ..... yrs. ..... mos. 0 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. S. Taylor, M. D.

3/7, 1944 (Address) 522 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL 3/9/ 1944

20 UNDERTAKER Chas. H. Alexander

ADDRESS 927 Mount St.

N. B.—WHERE PHYSICIAN HAS ATTENDED THE DECEASED THIS CERTIFICATE MUST BE FILLED OUT AND SIGNED BY HIM. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 14828

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 14828

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Stockton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leroy Pruitt

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1943

8. AGE: Years | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Balto md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Leroy Pruitt
FATHER 13. Birthplace Calvert Co. Md

MOTHER 14. Maiden Name Mable Barnes
MOTHER 15. Birthplace Balto Md

16 (a) Informant Mable Barnes
(b) Address 2406 Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 7 (day) 44 (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1302 Pressman St

19 (a) (Date received by registrar) MAR 7 1944 (b) Hunting for Williams Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1944, at 2:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular, Primary.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner
Date signed 3-4-44

G 14829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14829 Registered No. 95B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 19 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Charles Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1909

8. AGE: Years 34 | Months 10 | Days 0 | If less than one day: hr min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Walker Mitchell
13. Birthplace Virginia

MOTHER
14. Maiden Name Mamie ?
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Jos. B. Nelson
(b) Address 1303 Presstman St

19 (a) (Date received by registrar) MAR 7 - 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1944 19 at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1944, to 3/3 1944, and that I last saw h[illegible] alive on 3/3 1944.

Immediate cause of death: Congestive failure — Duration: 1

Due to: Rheumatic Heart Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattner
Address B.C.H. Date signed 3/4/44 M. D.

G 14830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 14830 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 N. Vincent Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 4
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Vincent Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Tenchie Dotson (Trudie)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Robert
6 (c) If alive, give age years
7. Birth date of deceased Feb. 4, 1911
8. AGE: Years 33 | Months 8 | Days 1 | If less than one day hr. min.
9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home

FATHER
12. Name Harrison Dotson
13. Birthplace Virginia

MOTHER
14. Maiden Name Jennie Gray
15. Birthplace Virginia

16 (a) Informant Robt Dotson
(b) Address 511 Vincent Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman St

19 (a) MAR 7 1944 (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/44 8:14 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/44 2/7/44 and that I last saw him alive on 2/3/44

Immediate cause of death Carcinoma of the breast — Duration 3 yrs

Due to Metastasis of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Klein, M.D.
Address 904 Mass — Date 2/9/44

Huntington Williams, M.D. Registrar

G 14831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 14831 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 Allegany Pl.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Allegany Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1896

8. AGE: Years	Months	Days	If less than one day
47	11	7	hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Contractor

FATHER
12. Name Richard Johnson, Sr.
13. Birthplace West River, Md.

MOTHER
14. Maiden Name Grace Davidson
15. Birthplace West River Md.

16 (a) Informant Jean Marshall
(b) Address 713 Allegany Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Wm. H. Nelson
(b) Address 1303 Preastman St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3- 1944 at 4.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1944 to 3-3 1944 and that I last saw h[illegible] alive on 2-15 1944.

Immediate cause of death: Diabetic gangrene — Duration: 3 wks.
Due to Diabetes — 6 mos.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Page
Address 1814 N. Mount St (17) Date signed 3-7-44

D.O.A. 14 hours Dec 14832

G 14832

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 157E

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 / 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Anne's
(c) City or town Centerville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME Catherine Deedon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1	197		hr. min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Deedon
13. Birthplace

MOTHER
14. Maiden Name Sadie Bouldin
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-44 (month) (day) (year)
(c) Cemetery or crematory
Location Centerville, Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Bristol Hill Ave

19 (a) ..... (Delivered to Registrar) (b) ..... Registrar

MAR 7 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 5 1944, at 905 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 5 1944 to MAR 5 1944, and that I last saw h alive on ..... 19 .

Immediate cause of death: Cardiac failure — Duration

Due to pneumonia & anemia — Duration

Due to Congenital heart defect — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Large heart - pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter F. Kirschmann, M. D.
Address 3319 Wisteria Baltimore Date signed 3-6-44

G 14833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 42

G 14833
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Edward Apts #1 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ray Krees

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Isidore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 57 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unsp
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Isidore Krees
(b) Address Edward Apts #1

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore County

18 (a) Funeral director Jack Lemsky
(b) Address 1439 E. Balto St

19 (a) MAR 7 1944
(Date rec'd by registrar) Huntington Williams Asst Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/ 1943 to 3/6 1944
and that I last saw him alive on 3/5 1944

Immediate cause of death: Coronary Thrombosis

Due to: Abscess of Lung

Due to: Extraction of Tooth

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Stanton M.D.
Address 1331 Eutaw Pl Date signed 3/7/44

G 14834

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14834 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Llewellyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emanuel Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1942

8. AGE: Years 1 | Months 2/9 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Emanuel Williams
13. Birthplace Md.

MOTHER 14. Maiden Name Maggie Knox
15. Birthplace Md.

16 (a) Informant Mrs. Maggie Williams
(b) Address 2116 Llewellyn ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) 3-7-1944 (Date of registry) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5 1944 at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1944 to 3-5 1944 and that I last saw h[illegible] alive on 3-5 1944.

Immediate cause of death: Tuberculous Meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Campbell M. D.
Address Provident Hosp. Date signed 3/5/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14835 ✓ 107 (Registered No.) G-14835

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wolfe & Monument Streets
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1 Aberdeen
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL MORRISON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1944

8. AGE: Years	Months	Days	If less than one day
	2	23	hr. min.

9. Birthplace Aberdeen, Harford, Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Archie Morrison
13. Birthplace W. Va

MOTHER
14. Maiden Name Ora Brown
15. Birthplace W. Va

16 (a) Informant Archie Morrison
(b) Address Aberdeen RFD #1 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Abingdon Methodist
Location Abingdon Md

18 (a) Funeral director Howard K. McComas
(b) Address Abingdon Maryland

MAR 7 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1944, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobular pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. W. Allenmuller M.D.
Medical Examiner.
Date signed 3-3-44

G 14836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 14836

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or Institution South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 1621 Olive St. (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country

3 (a) FULL NAME Donna Maria Shearer. (Engine)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F. M.	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 6 1942

8. AGE: Years	Months	Days	If less than one day
1	8	29	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name Eli Shearer

13. Birthplace Md

MOTHER

14. Maiden Name Blanch Burns

15. Birthplace N.Y.

16 (a) Informant Mrs Blanch Shearer

(b) Address 1621 Olive St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/43 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Rt Tchis Highway Boro Md

18 (a) Funeral director William M Marsh

(b) Address 718 Light St

APR 7 - 1944 Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5-44 19 , at 11 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1944 to 3-5 1944, and that I last saw her alive on 3-5 1944.

Immediate cause of death	Duration
Bronchial Pneumonia	
Due to Measles.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles B. McDonald M. D.

Address 1213 Light St Date signed 3-6-44

VS 150

G 14837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

Registered No. G 14837

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Providence, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. (Rural) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Schock

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1924

8. AGE: Years	Months	Days	If less than one day
19	4	12	15 hr. — min.

9. Birthplace Lutherville Maryland (Town, county, and state)
10. Usual Occupation Packing Clerk
11. Industry or business Murray Corp, Towson, Md.

FATHER
12. Name Charles E. Shock
13. Birthplace Lutherville, Md.

MOTHER
14. Maiden Name Helen Augusta Brooks
15. Birthplace Bel Air, Md.

16 (a) Informant Charles E. Shock
(b) Address Providence, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 9 '44 (month) (day) (year)
(c) Cemetery or crematory Sater's Cemetery
Location Brooklandville, Md.

18 (a) Funeral director John Bierne's Sons
(b) Address Towson, Md.

MAR 7 - 1944 (Date rec'd by registrar) (b) Huntingtown Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944, at 2:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1944, to 19..., and that I last saw him alive on 3-5 1944.

Immediate cause of death Unknown
Mastoiditis, Lung Abscess
Due to Chronic Empyema Left and Bronchiectasis
Due to
Other Conditions Past History of Lung Abscess (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Same as above

Duration
1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry A. Bullis M. D.
Address Univ. Hospt Date signed 3-6-44

VS 3 Not necessary To be Approved By medical Examiner H.A.Bruce

G 14838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

20c

G 14838 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore General Hosp
(c) Hospital or institution: Rayner & Dukeland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 951 Brooks Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Bessie Wolff

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-4883

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Gustav
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day hr.	min.
55				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Sales Lady Hutzlers

FATHER
12. Name Wolf Adovitz
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie Baer
15. Birthplace Russia

16 (a) Informant William Julian Wolff
(b) Address 934 Chauncey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 W North Ave

MAR 7 1944

19 (a) (Date rec'd by Registrar) (b) Hunter Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1944 to March 7 1944, and that I last saw h.e.r. alive on March 7 1944.

Immediate cause of death Encephalitis — Duration

Due to Central Meningeal Apoplexy Syphilis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address West Baltimore Gen Hosp Date signed 3/7/44

G 14839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13c

G 14839 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 954 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. James E. Talley

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-7-1915

8. AGE: Years 28 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER 12. Name Joseph Williams

13. Birthplace

MOTHER 14. Maiden Name Ethel Talley

15. Birthplace

16 (a) Informant Ethel Armstrong

(b) Address 269 N. 130 St Balto City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 9 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore County, Md

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna Ave Huntingdon Williams

19 MAR 7-1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Mar 5 1944 and that I last saw him alive on Mar 5 1944.

Immediate cause of death Acute Tuberculosis — Duration 6 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address 703 W Lafayette Ave Date signed 3/7-44

VS 180

G 14840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 14840 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) 1d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E. 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS LOPEZ

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-44

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph alvin Lopez
13. Birthplace Baltimore

MOTHER
14. Maiden Name Nellie angelia young
15. Birthplace Baltimore

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location JOHNS HOPKINS MEDICAL SCHOOL MAR 7 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 7 1944 (Signature) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5 1944 at 2 w P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1944 to 3-5 1944, and that I last saw him alive on 3-5 1944.

Immediate cause of death: debility — Duration:
Due to (a) prematurity (6 m)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shamer M. D.
Address 3300 N. Charles ave Date signed

0.78

G 14841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

Registered No. G 14841

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner + Dukeland

(c) Hospital or institution: West Balto. Genl Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Balto. Haletown

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5629 Ashbourne Rd Haletown (Rural place designation)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME BABY DEAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/5/44

8. AGE: Years	Months	Days	If less than one day
			12 hr. 20 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas J-C-N

13. Birthplace Eastern Shore

MOTHER 14. Maiden Name Ruth Jean Brooks

15. Birthplace Balto. Md

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location JOHN HOPKINS MEDICAL SCHOOL MAR 7 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAR 7 1944 (Signature of registrar) Huntington Williams, M.D.

VS 150

0.79

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1944 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1944, to 3/6 1944 and that I last saw h/m alive on 3/6 1944.

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature P. N. Friedman

Address West Balt Genl Hosp Date signed 3/7/44 M. D.

G 14842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 14842 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 N. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Jones

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.) Aug. ~~1884~~ 1886

8. AGE: Years: 57 Months: 6 ? Days: ? If less than one day: hr. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Domestic

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Henry Jones
(b) Address: 503 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: A.A.County, Md.

18 (a) Funeral director: Charles G. Cooper
(b) Address: 512 N. Carrollton Ave.

19 (Date received by Registrar) MAR 7 1944 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/44 19 , at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20-1944 to 3-7-1944, and that I last saw h[illegible] alive on 2-3-1944.

Immediate cause of death [illegible]

Duration

Due to [illegible]

Due to [illegible]

Other Conditions [illegible]
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 726 N. Eutaw St. Date signed 3/9/44

(over)

3/5/08 14843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 14843 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Woodbrook Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Giles

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	male	black	Widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) [illegible] 1874

8. AGE: Years	Months	Days	If less than one day hr.	min.
69	2	3		

9. Birthplace D. C. (Town, county, and state)
10. Usual Occupation retired Laborer
11. Industry or business

MOTHER / FATHER
12. Name ?
13. Birthplace ?
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a. a. Co. Md

18 (a) Funeral director Charles S. Cooper
(b) Address 512 N. Catherine [illegible]

19 (a) MAR 7 - 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944 at 2 44/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1944, to 3-5 1944, and that I last saw h[illegible] alive on 3-5 1944.

Immediate cause of death
Cardiac failure — Duration

Due to Arteriosclerotic cardio-vascular-renal disease

Due to

Other Conditions Benign Prostatic hypertrophy
(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell B. Roth M. D.
Address Johns Hopkins Hosp. Date signed 3/5/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 14844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 14844 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Brevard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lemond White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	M

6 (b) Name of husband or wife Grace Marie White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 - 1910

8. AGE: Years	Months	Days	If less than one day
33	10	25	hr. min.

9. Birthplace Rock Hall - Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William G. White
13. Birthplace Rock Hall - Md

MOTHER
14. Maiden Name Lemma Jane Heath
15. Birthplace Rock Hall - Md

16 (a) Informant Mrs. Grace White
(b) Address 1201 Brevard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-44 (month) (day) (year)
(c) Cemetery or crematory Rock Hall
Location Rock Hall - Md

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Salmonden Ave

19 (a) MAR 7 - 1944 (Date the day registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5 1944, at 2 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1944 to Mar 5 1944 and that I last saw h[illegible] alive on March 5 1944.

Immediate cause of death: Lobar Pneumonia Bilateral

Due to

Due to

Other Conditions: Acute Nephritis Uremia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. J. Burgess M. D.
Address Provident Hosp Date signed 3/5/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14845 / 108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Adelle Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dale Bellman

3 (b) If veteran, name war None

3 (c) Social Security Account No 215-05-6231

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mildred

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) June 18, 1905

8. AGE: Years 38 | Months 8 | Days 16 17 | If less than one day: hr. min.

9. Birthplace Kansas (Topeka) (Town, county, and state)

10. Usual Occupation FIREMAN

11. Industry or business Penna. RR

FATHER
12. Name William Foster Bellman
13. Birthplace Indiana

MOTHER
14. Maiden Name Eva May Spencer
15. Birthplace Illinois

16 (a) Informant Wife
(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3 - 9 - 44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director Geo. F. Schubel
(b) Address 2101 Frederick Avenue

19 (a) (Date rec'd by registrar) **(b)** Huntington Williams

VS 150

MAR 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1944 at 1 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1944 to 3/5 1944 and that I last saw h/[illegible] alive on 3/5 1944.

Immediate cause of death Lobar pneumonia, Rt. upper middle & lower lobes

Duration

Due to

Due to

Other Conditions Agranulocytosis Congenital

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Rosecrans

Address St. Agnes Hosp. **Date signed** 3/7/44 M.D.

Please write clearly, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JO #30729 G 14846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

517

G 14846 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 114
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 W. Preston St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Christy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1888

8. AGE: Years	Months	Days	If less than one day
55	10	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Christy
13. Birthplace Maryland

MOTHER
14. Maiden Name Isabella Olson
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9, 1944 (month) (day) (year)
(c) Cemetery or crematory St. James Cemetery
Location Havre de Grace, Md

18 (a) Funeral director Thomas E. Bullock
(b) Address Havre de Grace, Md

19 (a) (b)
(Signature of registrar) Registrar

MAR 7 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March 1, 1944, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1944, to 3-1 1944, and that I last saw [illegible] alive on 3-1 1944.

Immediate cause of death

Duration

Metastasis ?
Due to ? Lymphogranuloma ?
? Carcinoma of penis ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold R. Webb M. D.
Address Balto City Hosp Date signed 3-7-44

G 14847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 14847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Homestead st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Homestead st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Geisel Rahe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John Rahe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12th 1880

8. AGE: Years	Months	Days	If less than one day
63	10	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Harry Quincy
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Mills
15. Birthplace Md.

16 (a) Informant Mrs Ruth Hasting
(b) Address 1411 Homestead st

17 (a) Burial (b) Date thereof 3/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Waverly

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul st.

19 (a) MAR 8 - 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th 1944, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1938 to 3/5 1944.
and that I last saw her alive on 3/5 1944.

Immediate cause of death Acute coronary occlusion — Duration 1/2 hr.
Due to —
Due to —
Other Conditions Diabetes - 7-8 yrs duration.
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Grayton M.D.
Address 3963 Greenmount Ave. Date signed 3/9/44

VS 150

Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

G 14848

AB-73627

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 14848 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. -10 mos.-7da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Pittman Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Ballard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12-1871

8. AGE: Years 72 | Months 3 | Days ~~24~~ 25 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name James Thomas Ballard
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza. Maihl-or-Eliz Maihl
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Md
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) MAR 8 - 1944 (Date rec'd by Registrar) Huntington Williams (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1944 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1942 to 3/7 1944 and that I last saw him alive on 3/7 1944.

Immediate cause of death: Pneumonia

Due to: Hypertensive Cardio-Vascular Lesions

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Acton, M.D.
Address B. C. H. Date signed 3/7/44 M. D.

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Information must be complete and correct age is especially important.

14849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G 14849
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 E. 28th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 E. 28th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius R. Haubert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Anna F. Haubert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29th 1885

8. AGE: Years	Months	Days	If less than one day
58	6	6	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Stock Keeper
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John Frederick Haubert
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Thome
15. Birthplace Germany

16 (a) Informant Anna F. Haubert
(b) Address 1913 E. 28th St

17 (a) Burial (b) Date thereof 3/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St
(c) Huntington for Williams, M.D.

MAR 8 - 1944
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5th 1944, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1-43 to 3/5/44
and that I last saw him alive on 3/4/1944

Immediate cause of death
Carcinoma Liver + Gall Bladder — Duration 3 mos
Due to
Due to Peptic Ulcer — 3 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. H. Herrmann
Address 1710 E 33rd St Date signed 3/6/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

14850
447500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B Registered No. 14850

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2850 N Charles (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank W. Watts
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-68

8. AGE: Years 75 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and State)
10. Usual Occupation President
11. Industry or business Watts-Pastor-Lear Co.

FATHER
12. Name Ben Watts
13. Birthplace Md

MOTHER
14. Maiden Name Mary Wise
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto., Md.

18 (a) Funeral director Wm. J. Dispeker & Son
(b) Address Balto., Md.

MAR 8 - 1944 (Date rec'd by registrar)
(b) Huntingtown, Md. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 7 1944, at 2.02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 10 1944, to MAR 7 1944, and that I last saw him alive on MAR 7 1944.

Immediate cause of death Carcinoma of urinary bladder with metastases — Duration

Due to

Due to

Other Conditions Arteriosclerotic cardiovascular disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Some

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell A. Robb, M.D.
Address Johns Hopkins Hosp. Date signed 3/9/44

Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Be sure correct age is especially important.

G 14851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14851 Registered No.

131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1728 Inc. Kean Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 Inc. Kean Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Elizabeth Inc. Finnis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles E. Inc. Finnis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23 - 1895

8. AGE: Years 49 | Months 1 | Days 12 | If less than one day 13 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Armenius Wirts
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Wild
15. Birthplace Baltimore Md

16 (a) Informant Charles E. Inc. Finnis
(b) Address 1728 Inc. Kean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10-1944 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Md.

18 (a) Funeral director Jeannie Cook Syfer
(b) Address 1600 W. North Ave.

19 (a) (Date Rec'd by Registrar) (b) Huntington Mills (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944 at 9-30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14/44 to 3/6/44, and that I last saw him alive on 3/5-44

Immediate cause of death: Coronary Thrombosis (Hemorrhage, Clot)
Due to Chronic Nephritis
Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 days; 20 yrs; 10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N C Howard MD
Address 1423 Eutaw Pl Date signed 3/7/44

VS 3

14852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

Registered No. G 14852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 W. Saratoga Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILSON MONTGOMERY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Married

6 (b) Name of husband or wife Mary Montgomery
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Lexington, Va (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name Wm. Montgomery
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mary Montgomery
(b) Address 1139 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. Md.

18 (a) Funeral director Wm. Francis A. Hemsley
(b) Address 378 W. Baltimore St

19 MAR 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1944, at 8:50 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage

Due to Gastric ulcer - perforation

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry L. Wollenweber, M.D. Medical Examiner.
Date signed 3-7-44.

For Henry L. Wollenweber by Howard Mendelson M.D.

✓ G 14853

14853 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 142 Washington Blvd. St., 11 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Infant of Mrs. Earl E. Dasch — If U. S. Veteran specify WAR

(a) Residence: No. 142 N. Washington Blvd, St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) May 6-44

7. AGE	Years	Months	Days	If LESS than 1 day hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md.

FATHER

13. NAME Earl E Dasch

14. BIRTHPLACE (city or town) (State or country) Balto Md

MOTHER

15. MAIDEN NAME Edith L Shipley

16. BIRTHPLACE (city or town) (State or country) Balto Md.

17. INFORMANT Mrs Edith L Dasch (Address) 142 Washington Blvd 30

18. BURIAL, CREMATION, OR REMOVAL Place Mt Olivet Date 3/8 1944

19. UNDERTAKER Edward Faulcon (Address) 2-5-9 Wash Blvd

MAR 8 - 1944 19 Registrar. Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 7, 1944

22. I HEREBY CERTIFY, That I attended deceased from May 6, 1944 to May 7, 1944

I last saw he alive on May 7, 1944. Death is said to have occurred on the date stated above, at 1350 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Premature birth.	11 hrs
Other contributory causes of importance: Premature birth.	May

Was an operation performed? No Date of —

For what disease or injury?

Name of operation None Date of

What test confirmed diagnosis? Blood Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

3/8/44 (Signed) P.L. Campbell M. D.
(Address) 1644 Hanover St

OCCUPATION IS ONLY important for persons 14 years of age and over.

14854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106B

Registered No. G 14854

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1430 Madison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town, give name of township, and write RURAL and give county)
(d) Street No. 1430 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard C. Henson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. School Boy

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-7-1930

8. AGE: Years 14 | Months 1 | Days 27 29 | If less than one day — hr. — min.

9. Birthplace Baltimore Md.
(Town, county and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER 12. Name Mathews Henson

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mildred Ray

15. Birthplace Baltimore Md.

16 (a) Informant Mathews Henson

(b) Address 1430 Madison St

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/10-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. G. Lowerty

18 (a) Funeral director Lotte Gross

(b) Address 1408 Ashland Ave.

MAR 8 - 1944 (b) Huntington Williamsport, Pa.
(Date rec'd by Reg. Dist.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6 1944 at 12·10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10·25 1943 to 3·6 1944
and that I last saw him alive on 3·4 1944

Immediate cause of death Bronchiectasis — Duration 6 Mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne

Address 1130 E. Madison St Date signed 3-7-44

Rayner Browne

VS 3

G 14855

AB-84520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 14855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos-10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Hesse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.-11-1866

8. AGE: Years 78 | Months 1 | Days 24 26 | If less than one day hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ? Hesse
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Kratz
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 9/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Pikesville, Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St.

19 (a) MAR 8 - 1944 (b) Huntington Williams, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1944, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1943, to 3/6 1944, and that I last saw him alive on 3/6 1944.

Immediate cause of death Coronary Thrombosis

Due to Generalized arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Acton, M.D.
Address B. C. H. Date signed 3/7/44

correct age is especially important. Physicians: please write the exact number of years, months and days.

G 14856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 14856 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Rocks, Harford County (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Georgiana Bradford

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George W. Bradford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/29/1871

8. AGE: Years	Months	Days	If less than one day
72	4	9	hr. min.

9. Birthplace Mill Green Harford County (Town, county, and state)
10. Usual Occupation Hwfe.
11. Industry or business

FATHER
12. Name DAVID NORRIS
13. Birthplace Md.

MOTHER
14. Maiden Name — SCARFF
15. Birthplace Md.

16 (a) Informant MRS. WILLIAM NORRIS
(b) Address Forest Hill, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 11/44 (month) (day) (year)
(c) Cemetery or crematory Fork Methodist
Location Fork Harford Co Md

18 (a) Funeral director Dealy Sons
(b) Address Relay Md

19 (a) MAR 8 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1944, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 7, 1944 to March 8, 1944, and that I last saw her alive on March 8, 1944.

Immediate cause of death — **Duration**

Acute Heart Failure
Due to
Hypertensive Arteriosclerotic
Due to Vascular Disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:

of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hayley B. Klyaucorr M.D.
Address St Joseph's Hosp Date signed 3-7-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 14857 ✓ G 14857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No.

Please write clearly and use ink. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 N Dallas St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Howard

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Andrew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Ayden North Car
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name —

13. Birthplace NC

MOTHER 14. Maiden Name Sicks ?

15. Birthplace NC

16 (a) Informant Leroy Howard
(b) Address 153 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7-1944 (month) (day) (year)
(c) Cemetery or crematory Int Calvary Cemetery
Location Old Court Rd

18 (a) Funeral director Robert Williams
(b) Address 1515 McElderry St

MAR 8 - 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1944, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1943 to 3-3 1944 and that I last saw h[illegible] alive on 3-2 1944

Immediate cause of death

Carcinomatosis

Due to

Carcinoma of cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

25. Signature Rayner Browne

Address 1570 E. Madison St Date signed 3/6

G 14858

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14858 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5220 Denmore Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 5220 Denmore Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. Same (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Grant Braxton

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Sadie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1879

8. AGE: Years	Months	Days	If less than one day
49 50	11	19	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business

12. Name Braxton
13. Birthplace Va
14. Maiden Name unknown
15. Birthplace Va

16 (a) Informant Sadie Braxton
(b) Address 5220 Denmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Freastman St.

19 (a) MAR 8 - 1944 (Date rec'd by registrar) (b) Huntingtown, Md (Registered No.)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1944 to March 3 1944, and that I last saw h[illegible] alive on March 3 1944.

Immediate cause of death	Duration
Bronchopneumonia	4 day
Due to Cerebral Hemorrhage	7 Day
Due to Arteriosclerotic Hypertension	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Higgins M.D.
Address 2243 Madison Ave Date signed 3/5/44

C 14859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

C 14859 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information must be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1366 Woodyear st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1366 Woodyear st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hortense Randall
3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	A.A.	Married

6 (b) Name of husband or wife Elijah Randall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-1866

8. AGE: Years	Months	Days	If less than one day hr.	min.
77 77	9	13	14	

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Makel
13. Birthplace Maryland

MOTHER
14. Maiden Name Melinda Smallwood
15. Birthplace Maryland

16 (a) Informant Mr. Elijah Randall
(b) Address 1366 Woodyear Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director George H. Kelson
(b) Address 1843 Eastman St

MAR 8 1944 Funeral Director, Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1944 at 11-36 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1943 to 3/3 1944 and that I last saw h[illegible] alive on 3/3 1944.

Immediate cause of death Hypertensive Cardio Vascular-Renal Disease — Duration 1 yr.
Due to
Due to Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carson C. Johnson
Address 1802 Penna Ave Date signed 3/7/44 M. D.

14860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 14860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Pinkett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	X

6 (b) Name of husband or wife Glenora Pinkett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1897

8. AGE: Years	Months	Days	If less than one day
46	4	21	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Wilson Pinkett
13. Birthplace md

MOTHER
14. Maiden Name Frances ?
15. Birthplace md

16 (a) Informant Glenora Pinkett
(b) Address 2228 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/44 (month) (day) (year)
(c) Cemetery or crematory Princess Anne
Location Co. Md

18 (a) Funeral director Wes. H. Kelso
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 6 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5 19 44 at 10 no A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 4 19 44 to Mar. 5 19 44; that I last saw h/ alive on Mar. 5 19 44.

Immediate cause of death: Lobar Pneumonia (Bilateral)

Due to

Due to

Other Conditions Hypostatic Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Burgess M. D.
Address Provident Hospital Date signed 3/5/44

Correct age if apparently important. Physicians: please write the causes of death clearly and legibly.

G 14861

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 14861 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 W Wyman Park apts (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALICE SMALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Wm. Small
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice E. Hardesty
15. Birthplace Baltimore

16 (a) Informant Miss Hanna McInnes Small
(b) Address 520 Wyman Park Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Charles J Evans & Co Inc
(b) Address 118 N. Mt Royal Ave, Hunting & Mt Royal

19 (a) MAR 8 - 1944 (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 44, at 5 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H L Wollenweber M.D. Medical Examiner.
Date signed 4-7-44

G 14862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 14862 Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. State Gen. Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 Madison St # 17 (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Edward Pryor

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-16-3601

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day hr.	min.
51				

9. Birthplace Mass (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Chas Pryor
13. Birthplace Va

MOTHER
14. Maiden Name Mary Wheeler
15. Birthplace Md

16 (a) Informant Cecilia Pryor
(b) Address 631 Madison st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 - 9 - 44 (month) (day) (yr.)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Ann Arundel Co.

18 (a) Funeral director Robert E. Jennings.
(b) Address 1501 madison ave

19 (a) [illegible] 1944
[illegible] Registrar
VS 186 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6 19 44, at 4 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 19 44 to 3-6 1944, and that I last saw [illegible] alive on 3-6 19 44.

Immediate cause of death Cardio-renal failure — Duration 10 days

Due to Leprosy

Due to Fracture & trauma of knee

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Feby ? 1944 at ? M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? public place While at work? yes (Specify type of place)
(e) Means of injury fell on sidewalk while walking

23. Signature [illegible] M. D.
Address Md. State Hosp. Date signed 3/6/44
Howard J. McFaddin, M.D.

14863 ✓ G 14863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

Registered No.

TB. 3[illegible]5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Newby Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	B.	Married

6 (b) Name of husband or wife Myrtle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1984

8. AGE: Years	Months	Days	If less than one day
60 50	?	?	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 8 1944 (b) Huntington Williams, MD
(Date rec'd by Local Reg.) Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/29 1944, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/[illegible]/[illegible] 19[illegible], to 2/27 1944, and that I last saw him alive on 2/28 1944.

Immediate cause of death Cerebral Thrombosis — Duration ?

Due to C.V.S. Lues

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Adams, M.D.
Address B. C. H. Date signed 3/6/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

10.83

14864

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 14864

CERTIFICATE OF DEATH

159

1.-PLACE OF DEATH 1732 Aliceanna

CITY OF BALTIMORE: (No.) ____ ST. ____ WARD) 2-3

REGISTERED No. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2.-FULL NAME Premature birth Thornburg

(a) RESIDENCE NO. 1732 Aliceanna ST., ____ WARD ____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced (or) WIFE of Ross Howard

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, 7 hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Wasely Moody

11 BIRTHPLACE OF FATHER (city or town) Mt Sterling Kentucky (State or country)

12 MAIDEN NAME OF MOTHER Ethel Thornburg

13 BIRTHPLACE OF MOTHER (city or town) Newark (State or country) Delaware

14 Informant

(Address)

15 MAR 8 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/44

17 I HEREBY CERTIFY, That I attended deceased from March, 19 44, to March, 19 44

that I last saw him alive on March, 19 44

and that death occurred, on the date stated above, at March 1744 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? NS

Did an operation precede death? NS Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Samuel Silverstein M.D.

, 19 (Address) 22 S. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHN HOPKINS MEDICAL SCHOOL

DATE OF BURIAL MAR 8 1944

20 UNDERTAKER F 0782 Commissioner of Health

ADDRESS

14865 G 14865

BALTIMORE CITY HEALTH DEPARTMENT

85913 CERTIFICATE OF DEATH 46 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Hillegas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ralph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16th, 1892

8. AGE: Years 51 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Mitchell
13. Birthplace Ky.

MOTHER
14. Maiden Name Hattie Smith
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Removed (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day), (year)
(c) Cemetery or crematory Cumberland Md
Location

18 (a) Funeral director Louis Steinacre
(b) Address Cumberland Md.

19 (a) (Signature of registrar) (b) Registrar

MAR 8 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1944, at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1944 to 3/7 1944, and that I last saw her alive on 3/7 1944

Immediate cause of death: Carcinoma of Stomach & Metastasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Acton, M.D.
Address B. C. H. Date signed 3/8/44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14866

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14866 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3036 Belmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 Belmont Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter W. Tompkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie E. Tompkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29, 1875

8. AGE: Years	Months	Days	If less than one day
68	10	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Police Sergeant
11. Industry or business Baltimore City

FATHER
12. Name Julian M. Tompkins
13. Birthplace Ill.

MOTHER
14. Maiden Name Margaret Brown
15. Birthplace Va.

16 (a) Informant Mrs. Annie E. Tompkins
(b) Address 3036 Belmont Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 9, 1944. (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave., Balto., Md.

18 (a) Funeral director W. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1944 at 3.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 , and that I last saw h alive on 19 .

Immediate cause of death Bilateral Extensive Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Carey Rostring
Address 324 W. Lombard St. Date signed 3/9/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14867 Registered No. 121

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S.Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Feb. 18, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since Feb. 18, 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Wis. (b) County
(c) City or town Sheboygan (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 S. 7th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME HARRY THEODORE GROH

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances Nowak
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1891

8. AGE: Years	Months	Days	If less than one day
52	3	20 21	hr. min.

9. Birthplace Sheboygan, Wisconsin (Town, county, and state)
10. Usual Occupation Captain, Tug A.H.Pitts
11. Industry or business

FATHER
12. Name William Groh
13. Birthplace Sheboygan, Wis.

MOTHER
14. Maiden Name Laura Boldt
15. Birthplace ? Wis.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-44 (month) (day) (year)
(c) Cemetery or crematory
Location Sheboygan - Wisc.

18 (a) Funeral director A. Lee Odle
(b) Address 4644 York Road

19 (a) Date received MAR 8 - 1944 (b) Registrar Washington Wilmarth, M.D.

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH March 6, 1944, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18, 1944 to Mar. 6, 1944, and that I last saw him alive on March 6, 1944.

Immediate cause of death Acute diffuse purulent peritonitis resulting from an acute perforation of the ileum. — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/1/44 - Appendicostomy Appendectomy

Major findings of operation: Very dilated cecum & ascending colon. Mass found in upper epigastric region, whether due to tumor or sinus formation is undetermined.

Autopsy? As above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J.C.Archer M. D.
Address Baltimore, Md. Date signed 3/7/44

PHYSICIAN
& Underline the cause to which death should be charged statistically.

MS-51101

G 14868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 35

Registered No. G 14868

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILSON JEANETTE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Bl	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 - 20 - 43

8. AGE: Years	Months	Days	If less than one day
1	-	14	hr. min

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Thomas WILSON
13. Birthplace New London, CONN.

MOTHER
14. Maiden Name Mary Rice
15. Birthplace Baltimore

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. C.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) MAR 8 - 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 4 1944, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 1944 to Mar 4 1944 and that I last saw her alive on Mar 4 1944.

Immediate cause of death	Duration
resp. failure	
Due to pneumonia	
Due to measles	
Other Conditions hydrocephalus mental retardation (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp. Date signed 3-7-44

G 14869 G 14869

AS-86674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 S. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Tarlton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4-1909

8. AGE: Years 34 Months 4 Days 3 If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Rose
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Weglein
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location Baltimore City

18 (a) Funeral director John H. Welsh
(b) Address 401 S. Chester Street

19 (a) 1944 (b) Registered by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1944, at 2.45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1944 to 3-7 1944, and that I last saw h[illegible] alive on 3-7 1944.

Immediate cause of death

? Hepato-Renal Syndrome

Due to Post operative Cholangiostomy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-3-44

Major findings of operation: Acute Cholecystitis

of autopsy:

Duration: 3 da

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald Austell M. D.

Address Balto City Hosp Date signed 3-7-44

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G 14870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14870 / 1310 Registered No.

Correct age in typewriting imperative. Typewrite, print or write the entries in black ink clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 435 ANGLESEA ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 5
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 435 ANGELSEA ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BARBARA A. HOFFMANN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife JOHN A. HOFFMANN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 24 1869

8. AGE: Years	Months	Days	If less than one day
74	3	12	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name CHARLES HORNER
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name KUNUGUNDA REIGEL
15. Birthplace BALTO. MD.

16 (a) Informant JOHN HOFFMANN (SON)
(b) Address 435 ANGELSEA ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 10/44 (month) (da) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

MAR 8 - 1944 Huntington Williams (Registrar)
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 6 1944 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1942 to 3-6 1944. and that I last saw h[illegible] alive on 3-5- 1944

Immediate cause of death a acute cardiac defect, fibrillation - Duration 3 mths. years?

Due to valvula disease of heart - chronic nephritis - years?

Due to

Other Conditions Hypertension -

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Demarest M. D.
Address Medical Arts Bldg. Date signed 3/7/44

G 14871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14871 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto., Md.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6703 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS B. HAGAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes Hagan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1876

8. AGE: Years	Months	Days	If less than one day
67	3	10	hr. min.

9. Birthplace Frederick, Maryland (Town, county, and state)
10. Usual Occupation Retired Machinist
11. Industry or business

FATHER
12. Name John G. Hagan
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Brenning
15. Birthplace Maryland

16 (a) Informant Agnes Hagan
(b) Address 6703 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 16-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Lilly and Beyer Inc
(b) Address 403 S. Wolfe St.

MAR 8 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7th 1944 at 11:22 A.M.

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intermuscular cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 3-7-44

14872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

Registered No. G 14872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette
(c) Hospital or institution:
Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 E Monument ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ada M Breeden

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 210-18-7015

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Earl S. Breeden

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 11, 1903

8. AGE: Years 40 | Months 7 | Days 26 | If less than one day: hr. ____ min. ____

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Pittsburg Plate Glass

FATHER
12. Name ——— Mock
13. Birthplace Va

MOTHER
14. Maiden Name Minnie Thompson
15. Birthplace Va

16 (a) Informant Earl S. Breeden
(b) Address 2720 E Monument ave

17 (a) Burial, cremation, or removal: Burial (b) Date thereof March 10 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto City

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles st

19 (a) Date received by registrar (Huntington Williams, M.D.) Registrar

MAR 8 1944

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1944, at 3 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-29 1944, to 3-7 1944; and that I last saw h-e alive on 3-7 1944

Immediate cause of death: Acute Cir. Collapse. — Duration: 3 hrs.

Due to Paralytic Ileus

Due to Appendicitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-1-44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Louis Vogt, Jr., M. D.

Address Bon Secours Hosp. Date signed 3-7-44

14873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14873
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 W. Bradley
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Roosevelt Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Mc.

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1905

8. AGE: Years 38 | Months 11 | Days – | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jerry Clayton
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace ? ? ?

16 (a) Informant Emma Clayton
(b) Address 1623 Madison Ave

17 (a) Burial (b) Date thereof March 9, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) [illegible] Registrar

MAR 8 – 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 7 1944. at 1 58 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1944. to Mar 7 1944. and that I last saw h/ alive on Mar 7 1944.

Immediate cause of death: Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Providence Hospital Date signed 3-27-44

Correct age is especially important. If unknown, please write the causes of death clearly and legibly.

G 14874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14874

Registered No. 1210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Echodale ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Echodale ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. KELLER

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frederick Keller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 18-1873

8. AGE: Years	Months	Days	If less than one day
71	1	15 16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace Germany
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Frederick Keller
(b) Address 3405 Echodale ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Funeral Parlor
(b) Address 5202 Harford Rd.

MAR 8 - 1944
(Date rec'd by registrar)

(a) Clayton Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 44, at 1 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from February 27 1944 to March 4 1944, and that I last saw her alive on March 3 1944

Immediate cause of death
Cerebral Hemorrhage — Duration 4 d.
Due to Arterio Sclerosis — 7 y.
Due to Hypertension — 7 y.
Other Conditions Chronic Nephritis — 7 y.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I P O Stevens M. D.
Address 3878 Harford Rd Date signed 3-6-44

correct age is especially important. If unknown, please write best estimate and state whether minutes, hours, days, months or years.

VS 150

G 14875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14875 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3132 Chesterfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3132 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel T. K. Summers

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-3037

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6-1875

8. AGE: Years	Months	Days	If less than one day
69	2	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Stella Summers
(b) Address 3132 Chesterfield Ave

17 (a) Burial (b) Date thereof 3-10-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Leonard H. Burke
(b) Address 5805 Harford Rd.

19 (a) (b)
(Date rec'd by Registrar) Registrar

MAR 9 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to MAR 7 1944, and that I last saw him alive on MAR 7 1944

Immediate cause of death	Duration
Hypostatic Congestion of Terminal Pneumonia	
Due to Bilateral Diffuse Atelectasis	
Due to Rheumatic Carditis	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ingalls A. Anderson M. D.

Address 3001 Sharon Drive Date signed March 8-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

Registered No. G 14876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 N. Amity St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (UNIDENTIFIED) MARY SALLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Raymond Salley
(b) Address 127 N. Amity St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) M.D. 8 - 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1944 at 8 A. M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-3-44 at 2 1/2 M.
(b) Where did injury occur? B & O R.R. tracts, Carroll Pk. west of Pulaski St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by train

23. Signature W. L. Wallenmeyer M.D. Asst. Medical Examiner.
Date signed 3-4-44

VS 151

G 14877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G 14877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 S. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSARIA PROVENZANO

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Francesco Provenzano
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8 1875

8. AGE: Years	Months	Days	If less than one day
68	5	27	hr. min.

9. Birthplace Valguarnera Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Luigi Veneziano
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Giunta
15. Birthplace Italy

16 (a) Informant Francesco Provenzano (Husband)
(b) Address 208 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md,

18 (a) Funeral director Frank Della Rocca
(b) Address 1132 No. Morley St.

19 (a) (Date rec'd by registrar) MAR 8 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1944, at 2:05 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 8, 1938, to March 6, 1944, and that I last saw h alive on March 6, 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 hours
Due to Arteriosclerosis	Unknown
Due to Nephritis	Unknown
Due to Myocarditis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Filiberto Antignani M. D.
Address 2942 E. Fayette St. Date signed 3/7/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14878
Registered No.

4878 / 108

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Rayner & Dukeland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Warden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earnest Warino Ernesto Marino

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	220-02-1963	male	White	Widowed

6 (b) Name of husband or wife late Lucy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6 1885

8. AGE: Years	Months	Days	If less than one day
58	5	1	hr. min

9. Birthplace Chiarino Italy
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business Fairfield Ship Yard Co.

FATHER
12. Name Battista Marino
13. Birthplace Italy

MOTHER
14. Maiden Name Carmela Marino
15. Birthplace Italy

16 (a) Informant Rocco Marino (Son)
(b) Address 1032 Warden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 1 E. Lexington St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 250
MAR 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 44, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 19 44, to 3/7 19 44, and that I last saw h[illegible] alive on 3/7 19 44.

Immediate cause of death
Lobar Pneumonia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address West Baltimore General Hospital Date signed 3/8/44

G 14879

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 14879 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 E. Clement St
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 V
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 E. Clement St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Mitchell

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 219-07-4282

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Elizabeth Mitchell
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1870

8. AGE: Years	Months	Days	If less than one day
73	6	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Label cutter
11. Industry or business U. S. Printing

FATHER
12. Name John Mitchell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah McCann
15. Birthplace Ireland.

16 (a) Informant Mrs. Wm. Mitchell
(b) Address 529 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 9/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Fred. A. Krause & Son
(b) Address 2416 Charles St.

19 (a) MAR 8 - 1944 (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 5 1944 at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1943 to 3-6 1944 and that I last saw him alive on 3-5 1944.

Immediate cause of death: Chronic Myocardial Degeneration — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Ballod M. D.
Address 7026 Fortlee. Date signed 3-7-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Registrar

G 14880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944 G 14880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Campbells Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Campbells Lane
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sidney Wesley Powell

3 (b) If veteran, name war ~

3 (c) Social Security Account No. 228-18-2056.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Sara Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1869

8. AGE: Years	Months	Days	If less than one day
74	5	20	22 hr. ~ min.

9. Birthplace Marion Sta. Maryland.
(Town, county, and state)
10. Usual Occupation Warehouse Man.
11. Industry or business Grocery.

FATHER
12. Name Henry Powell
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Ball
15. Birthplace Maryland

16 (a) Informant Daughter - Mrs Field
(b) Address 511 Campbells Lane

17 (a) Removal (b) Date thereof 3 / 8 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Johnston Cemetery
Location Eastville, Va.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road.

19 (a) 1944 Registrar
(Date rec'd by reg. Dist.)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1944, to 3-8 1944, and that I last saw him alive on 3-8 1944.

Immediate cause of death: Chronic Myocarditis.
Duration: ?

Due to Acute Cardiac Dilatation
Duration: 1 hr.

Due to

Other Conditions ~
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Cole M. D.
Address 6014 York Road Date signed 3-8-1944.

G 14881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G 14881

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 W Lee
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs.) mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 W. Lee (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME Eva Walker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Thomas Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1884

8. AGE: Years	Months	Days	If less than one day
59	2	7	hr. min.

9. Birthplace Faber Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Joe Green
13. Birthplace Va

MOTHER
14. Maiden Name Esther —
15. Birthplace Va

16 (a) Informant Howard Walker (S)
(b) Address 517 W Lee St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory Charlottsville
Location Va

18 (a) Funeral director Isaiah L. Brown, Sr
(b) Address 108 W Montgomery St

19 (a) Received (b) MAR 8 1944 Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1944, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1944, to 3/6 1944 and that I last saw h alive on 3/6 1944

Immediate cause of death Lobar Pneumonia — Duration

Due to Septicemia & Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan Gilkes

Address 601 N. Calhoun St Date signed 3/8/44

EVAN GILKES

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14882 77c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 Eutaw Place
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 St. Benedict St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Donald R. Barber (DONALD R. BARBER)

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 25-1906

8. AGE: Years	Months	Days	If less than one day
37	11	8	10 hr. min.

9. Birthplace Vermont.
(Town, county, and state)
10. Usual Occupation Machine tool maker
11. Industry or business Supplement machine Co.

FATHER
12. Name Jesse L. Barber
13. Birthplace Vermont.

MOTHER
14. Maiden Name Francis A. Smith
15. Birthplace Vermont.

16 (a) Informant Jesse L. Barber
(b) Address Tenmile, Vermont.

17 (a) [redacted] (Burial, cremation, or removal) (b) Date thereof Mar 9/44 (month) (day) (year)
(c) Cemetery or crematory Prospect
Location Bergenfield Vermont

18 (a) Funeral director F. B. WIPPERT. SON
(b) Address 1911 Eutaw Place

MAR 8 1944

19 (a) (Date rec'd by registrar) (b) Harriet L. Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1944, at 1:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 6, 1944

G 14883

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1163H

G 14883
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Bennett Way (If rural give location)
(e) Citizen of foreign country? Leonardtown (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA J. GILES

3 (b) If veteran, name war: V
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Harry Giles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1848

8. AGE: Years 96 Months | Days | If less than one day ... hr. ... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Employed at Glenn L. Martin Co
11. Industry or business

FATHER
12. Name Thos Jones
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Claud S. Showers
(b) Address Leesburg Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 10 44 (month) (day) (year)
(c) Cemetery or crematory Northfork W. Va
Location Northfork W. Va

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) MAR 8 - 1944 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944, at 6 30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to Suicide

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-6-44 at M.
(b) Where did injury occur? at home address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
Means of injury kitchen gas stove

23. Signature H. L. Wollenmaier M.D.
Medical Examiner.
Date signed 3-7-44

VS 151

G 14884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14884 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Jan.11,1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since Jan.11,1944

2. USUAL RESIDENCE OF DECEASED: Legal residence: Urbanna, Virginia
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Frederick Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE VAN WAGENEN

3 (b) If veteran, name war - Sp.American War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married, but separated.
6 (b) Name of husband or wife ??
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 4, 1864
8. AGE: Years 79 Months 8 Days 3 If less than one day hr. min.
9. Birthplace Albany, N.Y. (Town, county, and state)
10. Usual Occupation Captain, Cecelia
11. Industry or business "

FATHER
12. Name David Van Wagenen
13. Birthplace Albany, N.Y.

MOTHER
14. Maiden Name Emily Crittenhan
15. Birthplace Va.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 9 - 1944 (month) (day) (year)
(c) Cemetery or crematory Urbanna, Va. Location Middlesex Co Va

18 (a) Funeral director Maurice Cook Byfer
(b) Address 1600 N. North Ave.

19 (a) (Date received by Registrar) (b) Registrar

MAR 8 - 1944

Flouting's or Whitestone, N.Y.

correct age is especially important. Physicians, please write the cause of death very plainly.

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 7, 1944, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11, 1944, to Mar. 7, 1944, and that I last saw him alive on Mar. 7, 1944

Immediate cause of death Pneumococcus empyema; & Tuberculous effusion

Due to

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 2/9 & 2/29 Major findings of autopsy: None done.

Aspiration of chest; 2/9 & 2/29 thoracentesis; 2/4-vein ligation rt. 2/9-part of rib removed & fluid removed.

Duration 1st- noted 1 mo. ago 2nd- Unk.

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W.S.Bean, Medical Director M.D.
Address Baltimore, Md. Date signed 3/8/44

MS-50358

14885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 14885 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Sharp St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Thomas.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1884

8. AGE: Years	Months	Days	If less than one day
59	6	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William H. Thomas
13. Birthplace N.C.

MOTHER
14. Maiden Name Eliza Johnson
15. Birthplace Md

16 (a) Informant Lillie Cornish
(b) Address 135 W Hemmitte

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 1018 W Montgomery St

MAR 9 - 1944

19 (a) (Date rec'd by registrar) (b) Huntington Mills Baltimore, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 4 1944 to Mch 6 1944 and that I last saw h[illegible] alive on Mch 6 1944

Immediate cause of death Cardiac Embolism — Duration 2 hr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 3/9 1944 M. D.

VS 150

0

14886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G 14886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 China St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1887

8. AGE: Years	Months	Days	If less than one day
56	5	-	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Spence
(b) Address 906 China St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary St
Location A. A. Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) MAR 9 - 1944 (Date rec'd by registrar) (b) Hunting & Kilby Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944, at 7:15 M A

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Pelvis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 21/1
(a) Date of injury Feb 21st 1944 M.
(b) Where did injury occur? 906 China St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury? Fell down steps of kitchen

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 6, 1944

14887

JO 906714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 14887
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days). ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Walnut Alley Warner (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Hughes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1897

8. AGE: Years	Months	Days	If less than one day
46	11	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation car loader
11. Industry or business

FATHER
12. Name Samuel Hughes (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Etta ? (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery St

19 (a) MAR 9 - 1944 (b) Registrar
(Date rec'd by Registrar)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1944, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 1944 to 3/4 1944, and that I last saw him alive on 3/4 1944.

Immediate cause of death Lobar pneumonia, left;

Duration 10 d.

Due to Prob. pneumococcus

Due to

Other Conditions Chronic endocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergeon M.D.
Address BCH Date signed 3/6

G 14888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G 14888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Archer St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lemon

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-44

8. AGE: Years | Months | Days 1 day | If less than one day hr. min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Lemon
13. Birthplace Marion S. Carolina

MOTHER
14. Maiden Name Annie Myrle
15. Birthplace Marion S. Carolina

16 (a) Informant Joseph Myrle
(b) Address 536 W. Lee St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 9 44
(Month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Md.

18 (a) Funeral director Walter P. Boyle
(b) Address 1 3a N. Hamley Ave

19 (d) MAR 9 - 1944 (Date rec'd by registrar) (b) Huntington Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1944 to 3-6 1944, and that I last saw her alive on 3-6 1944.

Immediate cause of death Respiratory failure - Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Kenyon M. D.
Address Univ. Hospital Date signed 3-6-44

VS 3

G 14889

FL - 86730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

✓ G 14889

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 605 N. Montford Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John Hildebrand

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1889

8. AGE: Years	Months	Days	If less than one day
54	2	7	hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation North East Market

11. Industry or business

FATHER

12. Name Charles Hildebrand

13. Birthplace Md.

MOTHER

14. Maiden Name Dora Sausch

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3-11-44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Mem. Park

Location Taylor Ave.

18 (a) Funeral director John C. Milby Inc

(b) Address 2425 E. Oliver St

19 (a) MAR 13 1944 (b) Registrar

(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1944 to 3-8 1944, and that I last saw h[illegible] alive on 3-8 1944.

Immediate cause of death Pulmonary TB

Duration
?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul Head M. D.

Address B. C. H. Date signed 3/8/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14890

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14890 Registered No. 176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparrows Pt (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2516~~ 2518 Hughes Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. FREDERICK WELSH Jr

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-1484

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen Mae Welsh

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Nov. 11 1912

8. AGE: Years 31 | Months 3 | Days 24 25 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Checker

11. Industry or business Bethlehem Sparrows Pt

FATHER
12. Name J. Frederick Welsh
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary Eo. Bush
15. Birthplace Balto Co. Md

16 (a) Informant Helen Mae Welsh
(b) Address 2518 E. Hughes Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-9-44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Mem
Location Eastern Ave.

18 (a) Funeral director Ray C Miller Inc
(b) Address 2435 E. Oliver St

19 (a) MAR 9 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 44 at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushing of chest and arms

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-6-44 M.
(b) Where did injury occur? Bethlehem Steel Sparrows Pt
(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? yes
(d) Means of injury crushed by high speed drill

23. Signature [illegible] M.D. Medical Examiner.
Date signed 3-7-44

VS 151

G 14891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14891 Registered No.

ID - 86728

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Roper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Selly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1859

8. AGE: Years	Months	Days	If less than one day
85	0	17	hr. min.

9. Birthplace N. J. (Town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

FATHER
12. Name Lansdale Roper
13. Birthplace Pa.

MOTHER
14. Maiden Name Matilda Lake
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location O'Donnell St.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) MAR 9 1944 (Date received by Registrar) (b) Huntington Hill (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1944 at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1944 to 3/6 1944 and that I last saw him alive on 3/6 1944.

Immediate cause of death Cardiac decompensation

Due to Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Acton, M.D.
Address B. C. H. Date signed 3/8/44 (M.D.)

G 14892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1702

G 14892
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 0 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6701 Holabird Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country U. S.

3 (a) FULL NAME William E. (m) Panfilis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife Argiro Panfilis
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) May 24. 1895

8. AGE: Years	Months	Days	If less than one day
48	8 9	1 2	hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation
11. Industry or business Restaurant & Saloon

FATHER	12. Name Emmanuel Panfilis
	13. Birthplace Greece
MOTHER	14. Maiden Name Stamatina Papanikolaou
	15. Birthplace Greece

16 (a) Informant Mrs Leona Panfilis
(b) Address 305 N. Greene St.

17 (a) Burial (b) Date thereof 3 9 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Leonard L. Legg
(b) Address 21 W. 25th St.

19 (a) MAR 9 - 1944 (b) [illegible] Registrar
(Registered by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1944, at 11:05 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-6-44 at 10:30 A. M. 26/6
(b) Where did injury occur? Dundalk + Holabird Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Auto into streetcar.

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 3-6-44.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14893

YA-86786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 14893 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4240 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 760 McHenry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Effie Covington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Earl A. Covington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1877

8. AGE: Years 66 | Months 2 | Days 13 | If less than one day: hr min. 15

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name Daniel Baynard
13. Birthplace Md.

MOTHER
14. Maiden Name Hattie Jumps
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John F. Cowan & Son
(b) Address 9603 Hallows Street

19 (a) MAR 9 1944 (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1944 at 5 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1944, to 3-8 1944, and that I last saw her alive on 3-8 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: Hours

Due to: Hypertension Cardio-Vascular Disease — Duration: 9

Due to: Diverticulumm of Esophagus — Duration: 7

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B. Stubbs M. D.

Address Balto City Hosp Date signed 3-8-44

G 14894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 G 16834 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 710 Reservoir street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County --

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 710 Reservoir street

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME CATHERINE V. McGOVERN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
--	none	Female	white	Widow

6 (b) Name of husband or wife Joseph McGovern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1861

8. AGE: Years	Months	Days	If less than one day
83	1	16	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Patrick Flannery

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Burke

15. Birthplace Ireland

16 (a) Informant Joseph McGovern, Jr.

(b) Address 707 Newington avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director Chas. J. Evans & Son

(b) Address 119 N. Mt. Royal Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 1943 to Mch 7 1943 and that I last saw h-- alive on Mch 7 1943

Immediate cause of death

Chronic Myocarditis

Due to Chronic Ulcers --

Due to Senility

Duration
15 Yrs
15 Yrs
-

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Mrs. Geo. F.

Address 622 Mulberry Date signed 3/10/44

G 14895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G 14895

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 350 E. University Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 350 E. University Parkway (If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Rebecca R. Treadwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ William A. Treadwell
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1857

8. AGE: Years	Months	Days	If less than one day
76	2	20	--hr. ---min.

9. Birthplace Harford County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name Daniel Ehrhart
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Rachael Conley
15. Birthplace Pennsylvania

16 (a) Informant Charles W. Treadwell
(b) Address 3313 Shannon Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Friendship
Location Fallston, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert Street

19 (a) Date rec'd (b) Registered by Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1944 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1943, to Mar. 7, 1944, and that I last saw h~~e~~ alive on Mar. 7, 1944.

Immediate cause of death	Duration
Acute Myocardial Failure	1 week
Due to Chronic Myocarditis	1 years
Due to ✓	
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury ✓

23. Signature Grant H. Cydrus M. D.
Address 2701 N. Calvert Date signed Mar. 9/44

Dr. John Husband 1217 Poplar Grove St

C 14896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registration No. C 14896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3115 Baker st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 Baker st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louisa M. Maxon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Charles T. Maxon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1856

8. AGE: Years	Months	Days	If less than one day
87	2	12	hr. min.

9. Birthplace Louisville Kentucky (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Susie Scherer
(b) Address 3115 Baker St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A.A. Co., Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 9 1944

Burial to Millersville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 7 1944, at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1943 to Mar 7 1944 and that I last saw her alive on Mar 7 1944

Immediate cause of death: Uremia Acute Dilatation of Heart — Duration ✓
Due to: Chronic Interstitial Nephritis ✓
Due to:
Other Conditions ✓

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation ✓
of autopsy: not done

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? (Specify type of place)
(e) Means of injury ✓

23. Signature John A. Graham
Address 1219 Poplar Grove Date signed 3/9/44

G 14897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 926

G 14897 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1547 Leslie st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1547 Leslie st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HILTON R. FORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife Ruth Ford.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1903

8. AGE: Years	Months	Days	If less than one day
40	5	23	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business

FATHER
12. Name Upshur Ford
13. Birthplace Virginia

MOTHER
14. Maiden Name Mahala Johnson
15. Birthplace Virginia

16 (a) Informant Ruth Ford.
(b) Address 1547 Leslie St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressman St.

19 (a) MAR 9 - 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944 at 12 45 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Valvular heart disease
mitral insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. W. Wallenmeyer M.D.
Medical Examiner.
Date signed 3-7-44

VS 151

G 14898 ✓ BALTIMORE CITY HEALTH DEPARTMENT G 14898
Registered No.

CERTIFICATE OF DEATH 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4614 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary C. Schone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife J. Henry Schone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8. 1856

8. AGE: Years	Months	Days	If less than one day
88	1	0	hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Lawrence Hofstetter
13. Birthplace Baltimore Co. Maryland

MOTHER
14. Maiden Name Katherine Lutz
15. Birthplace Baltimore Co. Maryland

16 (a) Informant Mrs. Mary A. Harris
(b) Address 4614 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/43 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Luthern
Location Baltimore, Md.

18 (a) Funeral director Loach Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date received by registrar) (b) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8th. 1944 at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18-44 to 3-8-44, and that I last saw h[illegible] alive on 3-7 1944.

Immediate cause of death	Duration
Hypertensive Cardio Vascular disease -	1 yr.
Due to Arteriosclerosis -	
Due to Age -	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 5217 York. Date signed 3-8 44

G 14899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 14899 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 Bank St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Bank St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME HENRY BOECKNER (Henry B. Moser)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 213-12-2080

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ellen Mary McDonald Boeckner

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1873

8. AGE: Years 37 | Months 5 | Days 8 10 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Upholsterer

11. Industry or business

FATHER — 12. Name Jacob Boeckner
13. Birthplace Baltimore

MOTHER — 14. Maiden Name Wilhelmina Moser
15. Birthplace Baltimore

16 (a) Informant Mrs. Ellen M. Boeckner
(b) Address 1719 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore County, Md.
HENRY SANDER & SONS, INC.

18 (a) Funeral director
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) (b) Huntington Williams MD (Registrar)

MAR 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to March 6 1944 and that I last saw h[illegible] alive on March 6 1944.

Immediate cause of death: Acute Hypertrophied Dilated Congestive Arthritis

Duration: 2 days

Due to Chr. hydrocardetis & myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Sander
Address 1000 E. Fayette St. M. D.
Date signed 3/7/44

(over)

G 14900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

G 14900
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Calvert
(c) Hospital or institution:
Mercy Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town BALTIMORE, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Sachs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: MRS Isaac Sachs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1869

8. AGE: Years 74 | Months 7 | Days 4 | If less than one day: hr. 13 min. 11

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation NONE - Retired
11. Industry or business Grocer's agent

FATHER
12. Name Philip Sachs
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Admission History
(b) Address Un. Mem. Hosp.

17 (a) Burial (b) Date thereof 3/10/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harid Sonnerino & Son
(b) Address 1902 Eutaw Place

19 (a) MAR 9 1944 (b) Thursday
Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1944 to March 8 1944, and that I last saw h. IM alive on March 8 1944.

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to: Hypertensive Arterio-Sclerotic Heart Disease

Due to

Other Conditions: Perineal Prostatectomy
(Include pregnancy within 3 months of death)

Date of operation 3-7-44

Major findings of operation: Prostatic Hypertrophy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clayton J Van Bell M. D.
Address Mercy Memorial Hosp. Date signed 3-9-44

G 14901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 14901 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Monument & Rutland
(c) Hospital or institution: Sinai Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough & Aph. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Sylvan Rosenheim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Clara Rosenheim

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1874

8. AGE: Years	Months	Days	If less than one day
69	5	21?2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Surgeon

11. Industry or business

FATHER 12. Name Henry Rosenheim,
15. Birthplace Germany

MOTHER 14. Maiden Carrie Guggenheimer
15. Birthplace Germany

16 (a) Informant Mrs. Clara Rosenheim
(b) Address Marlborough & Aph.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery Oheb Shalom
Location Balto. Md.

18 (a) Funeral director David Lanzenheim & Son
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by Registrar) MAR 9 - 1944 (b) Registrar's Number

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1944 to 3-8 1944 and that I last saw him alive on 3-8 1944.

Immediate cause of death Coronary Cardiac failure

Due to Recent abdominal operation

Due to Intestinal obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-26-44

Major findings of operation: Carcinoma of cecum, obstructing

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lyon J. Lyons M. D.
Address Date signed

G 14902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 14902 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anne Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day hr.	min.
76				

9. Birthplace Washington (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name "
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR 10 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Winfield
(b) Address 914 Embalmers Inc

19 (a) MAR 9 - 1944 (Date rec'd by registrar) Washington Williams Registrar

VS 180

MEDICAL CERTIFICATION 10.15

20. DATE OF DEATH March 8 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Mch 8 1944, and that I last saw her alive on Mch 8 1944.

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed Mch 8 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14903 ✓ G 14903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3802 Ridgewood Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs., mos., or days 15 yrs.

15 1/2

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3802 Ridgewood Ave.
(If rural give location)

(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME BYRON PHELPS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Addie L. Phelps

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/27/1858

8. AGE: Years	Months	Days	If less than one day
85	3	11	hr. min

9. Birthplace A. A. Co., Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Allen Phelps

13. Birthplace Md.

MOTHER 14. Maiden Name Ann Gaither

15. Birthplace Md.

16 (a) Informant Mrs. May R. Stran, daughter

(b) Address 3802 Ridgewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month, day, year)

(c) Cemetery or crematory Nichols Mem. Cem.
Location Odenton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date received by local registrar) (b) (Signature of local registrar)

MAR 9 - 1944

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Mar. 8, 1944 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to 3/8 1944, and that I last saw h/m alive on 3/7 1944

Immediate cause of death Embolism to common iliac artery to rt brachial art.

Due to General Arterio Sclerosis & old age debility

Other Conditions Possible fracture of hip

(Include pregnancy within 3 months of death)

Duration

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Walter E. Greenberg

Address 4 or 3 Bea Lemmon, M.D.

Date signed 3/8/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 44a

(Registered No. 1)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6004 Eastern Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6004 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Garman

3 (b) If veteran, name war --

3 (c) Social Security Account No. 213 - 07 - 2297

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Garman
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 8/31/1885

8. AGE: Years 58 | Months 6 | Days 7 | If less than one day: hr. ____ min. ____

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Gen'l. Sup't. Bessemer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Christian Garman
13. Birthplace Pa.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Pa.

16 (a) Informant Mrs. Elizabeth Taylor
(b) Address 363 Folcroft St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/44 (month) (day)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 9 - 1944 (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 11 45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner
Date signed March 8, 1944.

VS 151

G 14905

G 14905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital. 17
(d) Length of stay in hospital or inst. ~~yrs.~~, or days 5
(e) Length of stay in Baltimore ~~yrs.~~, mos., ~~or days~~ 2 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2447 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick B. Harris

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 173-12-4615

4. Sex Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Joanna Harris

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Oct 9th 1883

8. AGE: Years 60 | Months 4 | Days 29 | If less than one day hr min.

9. Birthplace Somerton Ohio (Town, county, and state)

10. Usual Occupation Electrical Engineer

11. Industry or business General Electric Co

FATHER
12. Name John Harris
13. Birthplace Ohio

MOTHER
14. Maiden Name Adaline Warrick
15. Birthplace Ohio

16 (a) Informant Joanna Harris
(b) Address 2447 N. Calvert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3 9 44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ W. Alexander Pa.
Location

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 3:42 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from March 4 1944 to March 8 1944, and that I last saw h[illegible] alive on March 8 1944.

Immediate cause of death: Spontaneous subarachnoid hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan E Chenoweth

Address St Josephs Hospital signed 3/8/44

VS 150

14906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

V-G 14906 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Carroll St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 Carroll St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Parr

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Anna Parr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 81			hr. min.

9. Birthplace Wicomico Co. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Carpenter

FATHER — 12. Name	(unknown) Parr
FATHER — 13. Birthplace	"
MOTHER — 14. Maiden Name	"
MOTHER — 15. Birthplace	"

16 (a) Informant Ernest W. Parr
(b) Address 308 Belmont Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3 10 44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 W. Pratt St

19 (a) (Date rec'd by registrar) (b) Filed 3-13-44 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 19 44 at 5a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-Feb-44 to Mar 7 1944, and that I last saw h~~e~~r alive on Mar 7 1944.

Immediate cause of death Uremia — Duration 3 days.

Due to Chronic Nephritis — Duration 1 year

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Zierler M. D.
Address 231 Eastern Ave Date signed 3/8/44

G 14907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14907 Registered No. 121

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Fenlon Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. yrs. mos. days 6
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [illegible]
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5504 Windsor Mill Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Sakers

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-03-3123

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Virginia Sakers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17. 1893

8. AGE: Years 51 | Months 0 | Days 25 | If less than one day hr min

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Mercantile Trust Co.

FATHER
12. Name John N. Sakers
13. Birthplace Md.

MOTHER
14. Maiden Name Wilhelmina Sears
15. Birthplace Md.

16 (a) Informant Mrs. Virginia Sakers
(b) Address 5504 Windsor Mill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11-1944 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park.
Location Woodlawn Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3907 W North Ave

19 (a) (Date rec'd by registrar) MAR 9 - 1944 (b) Signature [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1944, at 8 ~~PM~~ AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3-2 1944 to 3-8 1944, and that I last saw him alive on 3-8 1944.

Immediate cause of death: Suppurative Peritonitis — Duration: 6 days

Due to Ruptured appendix

Due to

Other Conditions: Coronary Disease
(Include pregnancy within 3 months of death)

Date of operation 3-2-44

Major findings of operation: above

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically

23. Signature John D. Symmonds.
Address Md. Gen. Hosp. Date signed 3-8-44 M D

G 14908

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14908 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1637 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 1637 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Henderson Bell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mattie Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1900

8. AGE: Years 43 | Months 10 | Days 29 | If less than one day: hr. min

9. Birthplace Charlotte Co. Va.
(Town, county, and state)

10. Usual Occupation Labour

11. Industry or business

FATHER
12. Name John Bell
13. Birthplace Charlotte Co. Va.

MOTHER
14. Maiden Name Alma Hall
15. Birthplace Charlotte Co. Va.

16 (a) Informant Mattie Bell
(b) Address 1637 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-44 (month) (day) (year)
(c) Cemetery or crematory Charlotte Co. Va.
Location

18 (a) Funeral director Mrs Katy R Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944, at 4 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/8 1944 to 3/6 1944.
and that I last saw h alive on 3/4/44 19

Immediate cause of death Double lobar Pneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Wheelbrane M.D.

Address 1131 Harlem Date signed 3/8/44

G 14909

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 918a

G 14909 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Loudand & Green
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 152 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1943

8. AGE: Years	Months	Days	If less than one day
	2	7	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Clarence Austin
13. Birthplace Richmond N.C

MOTHER
14. Maiden Name Lillian Meeken
15. Birthplace Manteo N.C

16 (a) Informant Clarence Austin
(b) Address 152 W. Lanvale St

17 (a) Burial (b) Date thereof March 9, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (b)
(Date received by registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944 at 12 05 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3-6 1944 to 3-7 1944, and that I last saw h i m alive on 3-7 1944.

Immediate cause of death Pneumonia
Meningitis — Duration 3 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Kroupa M. D.

Address University Hosp Date signed 3-7-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 14910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 42c

(Registered No. 14910)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Ettings St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carlton Dunton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-23-29

8. AGE: Years	Months	Days	If less than one day
14	11	13	hr. min.

9. Birthplace Ceccomac Co. — Ja. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Dunton
13. Birthplace Keller-Ceccomac, Co.-Ja

MOTHER
14. Maiden Name Ethel
15. Birthplace Keller-Ceccomac Co-Ja

16 (a) Informant George Dunton
(b) Address 1122 Ettings Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1944 to Mar 6 1944, and that I last saw him alive on March 6 19 44.

Immediate cause of death	Duration
Rheumatic Heart Disease	
Due to Acute Rheumatic Fever	
Due to	
Other Conditions Mitral Stenosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E H Bonfield M.D.
Address Provident Hosp Date signed 3/8/44

G 14911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 121a

G 14911

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 Pearl st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL, and give town)
(d) Street No. 419 Pearl st (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Ada White Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edwards Walker

6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.) Sept. 5 1876

8. AGE: Years 67 | Months 6 | Days 29 | If less than one day: ____ hr. ____ min.

9. Birthplace Baltimore City Md. (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business Home Keeper

FATHER
12. Name Charles White
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Rebecca Ingold
15. Birthplace Balto Md

16 (a) Informant Edwards Walker
(b) Address 419 Pearl St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie A. Williams
(b) Address 322 N. Edmondson Av.

19 (a) MAR 9 1944 (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8/ 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1944, to Mar 4 1944, and that I last saw her alive on Mar 4 1944

Immediate cause of death: Acute Myocarditis (Duration: 1 wk.)

Due to: Interstitial Nephritis and Hypertension (Duration: 1 mo)

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations No
Of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. T. Gunn M. D.
Address 532 N. Arlington Ave. Date signed 3/9/44

VS 3

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G 14912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G 14912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 E. Jefferson St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Monasi

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-4218

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29-1913

8. AGE: Years	Months	Days	If less than one day
28	7	8	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation pipe fitter

11. Industry or business

FATHER
12. Name Michael Monasi
13. Birthplace Italy

MOTHER
14. Maiden Name Florinci Amorisa
15. Birthplace Italy

16 (a) Informant Mrs Tillie Tenace
(b) Address 100 S. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-1944 (month) (day) (year)
(c) Cemetery or crematory Mont Holy Redeemer
Location 4300 Belair Road

18 (a) Funeral director Joseph Tenace Inc,
(b) Address 2213 Gardenmount Ave

19 (a) (Date received by registrar) MAR 9 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 6, 1944 8:40 P M.
(b) Where did injury occur? 100 S. Bond St
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? Yes
(d) Means of injury Shot

23. Signature [illegible] M.D. Medical Examiner.
Date signed March 7, 1944

G 14913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 14913 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital of Baltimore, Inc.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3305 Sequoia Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ledie Brandenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William Brandenberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER 12. Name Jacob Edlavitch

13. Birthplace Russia

MOTHER 14. Maiden Name Kate Wolf

15. Birthplace Russia

16 (a) Informant William Brandenberg

(b) Address 3305 Sequoia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew Cem.

Location Belair Road

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

MAR 9 - 1944 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944 at 3:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1944 to March 7 1944, and that I last saw her alive on March 7 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Cerebral Hemorrhage	2 days
Due to Malignant Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Alfred H. Dann M. D.

Address Sinai Hosp. of Balto. Date signed Mar. 8, '44

G 14914 G 14914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Parkheights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 16
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Parkheights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob B. Berman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife: Late Rebecca S.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1857
8. AGE: Years 87 | Months | Days | If less than one day: hr. min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Bernard Berman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Yetta
15. Birthplace: Russia

16 (a) Informant: Mrs Jacob J. Stein
(b) Address: Fayetteville N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 10 44 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship Cemet
Location: 3600 E Biddle St

18 (a) Funeral director: Ad Levinson & Bro
(b) Address: 1124-26 W. North ave

19 (a) MAR 8 - 1944 (Date stored by registrar) (b) Pennsylvania Hospital

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944 at 4. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-15 1944 to Mch-8 1944 and that I last saw h[illegible] alive on Mch-8 1944

Immediate cause of death: Myocardial Insufficiency — Duration: indefinite prob about 15-20 yrs

Due to: Hypertension

Due to: Chronic Nephritis

Other Conditions: Cerebral-sclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Herman Levin M. D.
Address 2404 Eutaw Place Date signed 3/8/1944

G 14915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 14915 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3619 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3619 Falls Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Mather

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: William L. Mather
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 24 1863
8. AGE: Years 80 | Months 9 | Days 13 | If less than one day: hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Robert V. McCauley
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jane Haupt
15. Birthplace Maryland

16 (a) Informant Mrs. Mary C. Lovett
(b) Address 3619 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) March 8 1944 (Date received by registrar) (b) Huntington Hill Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to Mar 7 1944
and that I last saw h alive on Mar 6 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: quite a few (17 hours)
Due to: Cardio-vascular disease
Due to:
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 4646 W Belvedere. Date signed 3/8/44

G 14916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 14916 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Calvert St
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Patapsco Ave
(Do not give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) FULL NAME Mrs. Dorthea Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ Edward Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1876

8. AGE: Years	Months	Days	If less than one day
67	2	17	16 hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Fred Fitzgerald
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Sisson
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 3/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Old Frederick Rd.

18 (a) Funeral director John A. McGann
(b) Address 3010 E. Baltimore St.

19 (a) 1944 (b) Signature (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1944, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from February 14 1944 to March 8 1944, and that I last saw h[illegible] alive on 3/6 1944

Immediate cause of death Cardiac Regurgitation — Duration 5 Days
Due to Fatigue — 5 days
Due to Cerebro-Vascular accident. — 6 weeks.
Due to Hypertensive C.V. Disease + Congestive Failure
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Applegarth M. D.
Address Mercy Hosp Date signed

G 14917

TN. 65870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 14917 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Paca St (If rural give location)
(e) Citizen of foreign country? China (Yes or No)
If yes, name country

3 (a) FULL NAME Chin Ott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Chinese | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Eng. Yuek Lan.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10th, 1922

8. AGE: Years 22 | Months 1 | Days 28 | If less than one day: hr. min.

9. Birthplace China (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Chinfook Sang
13. Birthplace China

MOTHER
14. Maiden Name Look Shee
15. Birthplace China

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Goodlawn
Location

18 (a) Funeral director Stewart Mortuary
(b) Address

19 MAR 9 - 1944 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1944 at 8:42 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1944 to 3-8 1944 and that I last saw h[illegible] alive on 3-8 1944

Immediate cause of death: Pulmonary TBC

Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattina M.D.
Address BCH Date signed 3/8/44

14918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 14918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broad & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 8 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Eastern Ave (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Donald Lee (Chinese) DONALD LEE

3 (b) If veteran, name war no

3 (c) Social Security Account No. none

4. Sex Male

5. Color or race Chinese

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 21 1930

8. AGE: Years 13 | Months 7 | Days 16 | If less than one day hr. 17 min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Ling Lee
13. Birthplace California

MOTHER
14. Maiden Name Marie Chin
15. Birthplace China

16 (a) Informant Mildred Lee (sister)
(b) Address 1511 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3-10-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Stewart Mayer Co.
(b) Address 108 W Mt Royal Ave.

19 (a) MAR 9 - 1944 (Date rec'd by registrar) **(b)** [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 · 8 1944 at 12 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 · 8 1944 to 3 · 8 1944 and that I last saw h[illegible] alive on 3 · 8 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Gad Lyman M. D.
Address [illegible] Date signed 3-8-44

VS 3

G 14919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G 14919 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Chestnut St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Chestnut St. (Rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Leroy Turner

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4336

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Genevieve

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1898

8. AGE: Years 45 | Months 7 | Days 6 | If less than one day hr. min. 17

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Deck Captain

11. Industry or business

FATHER 12. Name Richard Turner
13. Birthplace Va.

MOTHER 14. Maiden Name Ella Sweland
15. Birthplace Calvert Co. Md.

16 (a) Informant Genevieve Turner
(b) Address 521 Chestnut St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9, 1944 (month) (day) (year)

(c) Cemetery or crematory Orbitas Mem. Pk. Location Balto Co. Md.

18 (a) Funeral director Mrs. George W. Holland
(b) Address 1400 Druid Hill Ave.

19 MAR 9 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1944 at 9:56 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1943 to 3/6 1944 and that I last saw him alive on 9 am 1944

Immediate cause of death: Glomerular Nephritis — Duration: 3 mos.

Due to

Due to

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. MacMorris Higgins

Address 723 Madison Ave Date signed 3/6/44 M. D.

G 14920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G 14920

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 N. Gilmor St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Lee Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1944

8. AGE: Years | Months | Days 17 | If less than one day hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation child

11. Industry or business

MOTHER / FATHER

12. Name Robert Johnson
13. Birthplace Md

14. Maiden Name Helen Johnson
15. Birthplace Md

16 (a) Informant Mabel Lee
(b) Address 917 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director R. Heuchert
(b) Address 916 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1944 to March 7 1944 and that I last saw her alive on March 7 1944

Immediate cause of death Bronchopneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Pechlin Jr.
Address 426 N. Gilmor St Date signed 3/15/44

VS 150

G 14921

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH ✓ 937

G 14921
Registered No.

Please write plainly, with pen or pencil. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address S. S. Meteor, Old Bay Line
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk (If outside city or town limits write RURAL and give town)
(d) Street No. 1527 Cedar Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERTA DAY RICHARDSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	Female	White	Widowed

6 (b) Name of husband or wife Capt. E. Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 23, 1873

8. AGE: Years	Months	Days	If less than one day
70	9	16	hr. min.

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Henry Day
13. Birthplace Portsmouth, Va.

MOTHER
14. Maiden Name Martha E. Fitchett
15. Birthplace Va.

16 (a) Informant Ernest E. Richardson
(b) Address 127 E. North Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 9, '44 (month) (day) (year)
(c) Cemetery or crematory Norfolk
Location Norfolk, Va.

18 (a) Funeral director Wm Cook, Inc
(b) Address 1217 St. Paul St

19 (a) MAR 9 1944 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1944, at 1 A. M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner
Date signed March 9 1944

14922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 14922
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1736 Webster Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Webster Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William May Albert

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband or~~ wife Sarah Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 1866

8. AGE: Years 78 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace N. Y.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Painter

FATHER
12. Name Herman A. Albert
13. Birthplace Germany

MOTHER
14. Maiden Name Margurete Jacobi
15. Birthplace Germany

16 (a) Informant Amelia P. Lacer
(b) Address 1736 Webster St

17 (a) Burial (b) Date thereof 3/10/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7- 1944, at 8 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-8-44

VD 151

MAR 1944

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BG 14923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 1318

G 14923

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:
U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) Just arr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County A A C

(c) City or town Linthicum Heights
(If outside city or town limits, write RURAL and give town)

(d) Street No. 303 Camp Meade Road
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY MARTIN CLOUGH

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1915

8. AGE: Years	Months	Days	If less than one day hr.	min.
28	11	14		

9. Birthplace Cambridge, Mass.
(Town, county, and state)

10. Usual Occupation Chief Guard, Curtis Bay Ord.

11. Industry or business "

FATHER

12. Name Harry Martin Clough

13. Birthplace Cambridge, Mass.

MOTHER

14. Maiden Name XXXX Sadie ?

15. Birthplace Cambridge, Mass.

16 (a) Informant Records, U.S.Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Bluff

Location Annapolis Md

18 (a) Funeral director O'Connor & Hopkins

(b) Address Annapolis, Md

19 (a) MAR 9 1944 (b) for Williams Registrar

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 8, 1944, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 8, 1944, to Mar. 8, 1944, and that I last saw him alive on Mar. 8, 1944.

Immediate cause of death Acute toxic hepatitis, nephritis & myocarditis — Duration Unk.

Due to Acute exfoliative dermatitis, of face and trunk - cause undetermined — Duration Claims 1-day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Street) (Number)

(e) Means of injury

23. Signature [signature]

Address Baltimore, Md. Date signed 3/9/44

Va-14353

G 14924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 14924

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 138 N. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Charles T. Albrecht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: White

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Mrs. C.T. Albrecht

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 31, 1882

8. AGE: Years 61 | Months 9 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation Upholsterer

11. Industry or business

FATHER
12. Name Mr. Charles D. Albrecht
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Johanna Strohmeyer
15. Birthplace BALTIMORE, Md

16 (a) Informant Admission sheet
(b) Address 138 N Kenwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 11-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ellison Funeral Home
(b) Address 2004-8 Eutaw St

MAR 9 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1944 to 3-9 1944.
and that I last saw h/m alive on 3-9 1944.

	Duration
Immediate cause of death Cardio-Respiratory Failure	
Due to Hypertensive Cardio-Vascular disease	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: TB. Scarring Calcified Glands.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lell M. D.
Address Union Memorial Hosp Date signed 3-9-44

G 14925

JL - 86708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14925
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Dover Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME G. Samuel Montgomery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1895

8. AGE: Years	Months	Days	If less than one day
48	9	25	hr min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Lawson, Montgomery
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Heschert
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Roff & B. M. Walters
(b) Address Pratt & Stricker Sts

19 (a) Filed (Registrar's signature) Hunting ton Williams, M.D. Registrar

MAR 9 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1944 at 10 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-29 19 YY to 3-8 19 YY, and that I last saw h alive on 3-8 19 YY.

Immediate cause of death Tuberculosis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Hattne M.D.
Address B.C.H. Date signed 3/8/YY

G 14926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 14926 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3717 Parkside Drive

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL, and give town)

(d) Street No. 3717 Parkside Dr (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ane Katherine Jensen

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Morgan C Jensen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11 - 1864

8. AGE: Years	Months	Days	If less than one day
79	3	26	27 hr. min.

9. Birthplace Randers Denmark (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER

12. Name Mitchell Lund

13. Birthplace Denmark

MOTHER

14. Maiden Name Rudelphine Fode

15. Birthplace Denmark

16 (a) Informant Emmy Morse

(b) Address 3917 Parkside Drive

17 (a) Funeral at (Burial, cremation, or removal) (b) Date thereof 3/9/44 (month) (day) (year)

(c) Cemetery or crematory Alpine

Location Hillcrest Cemetery, N.J.

18 (a) Funeral director Leonard J. Fitch

(b) Address 5305 Harford Ave. Registered in Maryland

19 (a) MAR 9 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 4 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1943 to March 8 1944, and that I last saw h alive on March 8 1944.

	Duration
Immediate cause of death: Bronchial Pneumonia	5 d.
Due to Mitral Regurgitation Accompanied	2 mo 13 d
Due to Chronic Interstitial Nephritis	2 mo 13 d
	12 mo 13 d
Other Conditions Arteriosclerosis Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thos. Pa Stearns M. D.

Address 2878 Harford Rd Date signed 3-8-44

G 14927 G 14927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 1226

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood
(c) Hospital or institution: University 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada E. Frantz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28 1879

8. AGE: Years	Months	Days	If less than one day
64	10	10	hr. min.

9. Birthplace Balto Co. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Elam G. Frantz
13. Birthplace Penna.

MOTHER
14. Maiden Name Martha B Funk
15. Birthplace Penna

16 (a) Informant Etha M. Frantz
(b) Address Reisterstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 11 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto Co.

18 (a) Funeral director J. F. Elline & Sons
(b) Address Reisterstown Md

19 (a) MAR 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944 at 5 ~~P.M.~~ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7-1944 to 3-9 1944 and that I last saw her alive on 3-9 1944

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary Embolism	
Due to Operation for intestinal obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3-2-44

Major findings of operations adhesions small intestine

of autopsy Some thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L L Wilson M. D.
Address Univ. Hosp. Date signed 3-9-44

VS 2

G 14928 Transcript G 14928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 Boone
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Boone St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth C Rolfe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day hr.	min.
75	—	—		

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name	Wm Gill
FATHER — 13. Birthplace	Ireland
MOTHER — 14. Maiden Name	Mary Gill
MOTHER — 15. Birthplace	Ireland

16 (a) Informant Mrs Doyle
(b) Address 2703 Boone St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 11-1944 (month) (day) (year)
(c) Cemetery or crematory Moreland P. Cemetery
Location —

18 (a) Funeral director Mary M Wyckfield
(b) Address 201 E 22nd St

19 (a) (Date rec'd by registrar) (b) [illegible] Williams Registrar

MAR 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1944 to March 8 1944, and that I last saw h er alive on MARCH 1 1944.

Immediate cause of death
Chronic Myocarditis
Arteriosclerosis

Duration
?
?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor Goldberg MD

Address 300 Harford Road Date signed 3/8/44 M. D.

G 14929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14929 Registered No. 157B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St. Jose-h's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Rutledge Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Joseph Abrams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace St. Joseph's Hospital Balto Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter Gilbert Abrams
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Marie Bafel
15. Birthplace Baltimore. Md.

16 (a) Informant Mr Walter Abrams
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Mary M. Feyth Sons
(b) Address 911 Harlem Ave. Baltimore, Md.

19 (a) MAR 9 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1944 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 29 1944 to March 9, 1944, and that I last saw him alive on March 9, 1944.

Immediate cause of death Pneumonia — Duration

Due to Post operative of spinal bifida.

Due to

Other Conditions Lumba spinal bifida.

(Include pregnancy within 3 months of death)

Date of operation March 1, 1944

Major findings of operation: Large meningocoele containing nerve fibers.

of autopsy: pneumonia left lung.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Thain Smith M.D.
Address 1 E Lexington St Date signed 3/9/44

G 14930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14930 Registered No. 108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 W. Clement
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth VOGLER.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W. Balto	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1865

8. AGE: Years	Months	Days	If less than one day
79		23	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Governess
11. Industry or business Private Home

FATHER
12. Name Matthias Vogler
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dont know
15. Birthplace

16 (a) Informant Portia Valentine Weissenborn
(b) Address 2325 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Balto Cemetery
Location Balto

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Lakewood Ave

MAR 9 – 1944 (Date death registered) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1944 at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944 to 3/5 1944 and that I last saw her alive on 3/5 1944.

Immediate cause of death: Embolism of iliac artery.
Due to Arterio sclerotic heart disease.
Due to G. Paresis syphilis
Other Conditions Labor pneumonia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1413 Light St Date signed 3-9-44

G 14931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14931 X 159 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA (b) County
(c) City or town Mercersberg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Hazelton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb-15-1944

8. AGE: Years	Months	Days	If less than one day
		22	hr. min.

9. Birthplace 14 Township Rd. Dundalk Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Roy Hazelton
13. Birthplace Pa.

MOTHER
14. Maiden Name Wava Critchall
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-10-1944 (month) (day) (year)
(c) Cemetery or crematory Union Cem
Location Fulton Co. Penna.

18 (a) Funeral director John H. Kelso
(b) Address McConnellsburg Pa.

19 (a) (Date received by registrar) Registrar

MAR 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 8 1944, at 1135 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 3-8 1944.

Immediate cause of death Respiratory failure — Duration

Due to Pneumonia

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harriet G. Guild
Address Johns Hopkins Hosp. Date signed 3/9/44

G 14932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

G 14932 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2231 W. Baltimore St
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4 Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth E. Smith
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 13 1906
8. AGE: Years 37 Months 7 Days 25 If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James L. Smith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sara E. Weber
15. Birthplace Baltimore Md

16 (a) Informant Shirley E. Smith
(b) Address 2231 W. Baltimore St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar 11-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director F. S. Kappat Son
(b) Address 300 Eutaw St

19 (a) MAR 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8th 1944 at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to Mar 8 1944, and that I last saw h[illegible] alive on 3/7 1944.

Immediate cause of death: Carcinoma Of Bladder — Duration: 1 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? at M (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Bahn
Address 2145 W Balt St Date signed 3/9/44 M.D.

G 14933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14933 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore St. Cor Dover
(c) Hospital or institution: N.W.C. Balto. + SMALLWOOD Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2458 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest L. Milligan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7 - 1900

8. AGE: Years	Months	Days	If less than one day
43	7	1	hr. min.

9. Birthplace Baltimore md (Town, county, and state)

10. Usual Occupation Car Dispatcher

11. Industry or business Bell Transit Co

FATHER 12. Name Matthew H. Milligan

13. Birthplace Frederick Co. Md

MOTHER 14. Maiden Name Mary Murphy

15. Birthplace Md

16 (a) Informant Mary A. Bringfield

(b) Address 640 Fre. St & E. Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 12/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Frederick Co. Md

18 (a) Funeral director F. B. WIPPERT SON

(b) Address 1300 EUTAW-PLACE

MAR 10 1944 (Date rec'd by registrar) (c) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed March 8 1944

14934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 14934
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hospital 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 Ceci Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith Leach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M.

6 (b) Name of husband or wife Harry Leach
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1870

8. AGE: Years	Months	Days	If less than one day
73	4	28 27	hr. min.

9. Birthplace ~~Md~~ Waynesboro, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name T. S. Nevin
13. Birthplace Waynesboro, Pa.

MOTHER
14. Maiden Name Mollie Hoddinott
15. Birthplace Philadelphia Pa.

16 (a) Informant Harry Leach
(b) Address 2216 Ceci Ave Baltimore Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery or crematory Hayes Hill Cemetery
Location Waynesboro, Pa

18 (a) Funeral director Walter F. Hess
(b) Address 27 Church St. Waynesboro Pa

19 (a) MAR 10 1944 (Date received by Registrar) (b) Huntington Williams, Jr. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9-44 19 . at 8 09 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6 1944 to 3-9 1944, and that I last saw her alive on 3-7 1944.

Immediate cause of death Cardiac failure

Due to arteriosclerotic CVD
interstitial fibrosis

Due to primal hypertension
arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Robertson M. D.
Address University Hospital Date signed 3-7-44

G 14935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87c

Registered No. G 14935

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2315 Mc Culloh St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2315 Mc Culloh St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME William C. Leakins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lucy E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1880

8. AGE: Years 63 | Months 7 | Days 21 | If less than one day hr. min. 64

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER 12. Name Cornelius Leakins

13. Birthplace Frederick, Md.

MOTHER 14. Maiden Name Celia Lee

15. Birthplace Frederick, Md.

16 (a) Informant Lucy Leakins

(b) Address 2315 Mc Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 1944 (month) (day) (year)

(c) Cemetery or crematory St. Peters Cem.

Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Dyllard

(b) Address 1631 Druid Hill Ave

MAR 10 1944 Huntington Williams M.D.

(Date rec'd) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938 to March 1944, and that I last saw him alive on 3 — 6 1944.

Immediate cause of death Carcinoma of Colon

Due to Paralysis Agitans

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. B. Butler M. D.

Address 2033 Druid Hill Ave Date signed 3/9/44

G 14936

BALTIMORE CITY HEALTH DEPARTMENT G 14936 Registered No.

CERTIFICATE OF DEATH 95B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Md. Gen. Hosp. 16
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~, or days) 58
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lana McGriffith

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-06-5254

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: George A. Griffith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1871

8. AGE: Years 72 | Months 6 | Days 18 | If less than one day: hr min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation ~~Housekeeper~~ None

11. Industry or business

FATHER
12. Name William Bowen
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Fries
15. Birthplace Va.

16 (a) Informant Mrs. C. Howard Tickner
(b) Address 226 St. Dunstans Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 10 1944 (b) (Registered by number) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1944, to March 9 1944, and that I last saw h.e alive on March 8 1944.

Immediate cause of death: Coronary thrombosis — Duration

Due to Abdominal H.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. H. Williams M. D.
Address Md. Gen. Hosp. Date signed 3-9-44

14937 ✓ G 14937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
Snyder's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. TRAPPE

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Milton P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1866

8. AGE: Years	Months	Days	If less than one day
77	5	24	hr. min.

9. Birthplace Illchester, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace unknown

MOTHER
14. Maiden Name Laura ~~Smith~~
15. Birthplace Unknown

16 (a) Informant Mr. Milton P. Trappe,
(b) Address 1112 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 10 1944 (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1944, at 130a M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 10 1941 to March 8 1944 and that I last saw h[illegible] alive on March 8 1944.

Immediate cause of death
(a) Chronic Myocarditis — Duration indef
Due to
Due to
Other Conditions Arteriosclerosis indef
& Chronic Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify (a), (b), or (c) place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 17 W. 25th St. Date signed March 8, 44

14938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

✓ G 14938

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 W. 29th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 W. 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Jones

3 (b) If veteran, name war: World
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Elizabeth Hopkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 23, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	6	15		

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: William Henry Jones
13. Birthplace: -

MOTHER
14. Maiden Name: Amelia Rebecca Beckmyer
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. Lawrence Jones
(b) Address: 1406 Eastwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: Wm. J. Tuckner & Son
(b) Address: Baltimore, Md.

19 (a) MAR 10 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratzer M.D.
Medical Examiner.
Date signed March 9, 1944

G 14939

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14939 Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution: General German Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S Athol Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Ludwig W. Ottenbacher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1854

8. AGE: Years	Months	Days	If less than one day: hr.	min.
89	7	25	6	

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name unknown
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant General German Home
(b) Address 22 S Athol Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Ave.

18 (a) Funeral director Harry D. Whitlee
(b) Address 1401 Edmondson Ave

19 (a) (b) Registrar

MAR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944 at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 2/44 19 to Mch. 7/44 and that I last saw h in alive on Mch. 7/44

Immediate cause of death	Duration
Broncho-Pneuronia	5 days
Due to	
Due to	
Other Conditions Arterio-Sclerosis. Unknow	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Martin Stein, M.D.
Address 933 Hanover St. Date signed Mch. 7/44

G 14940 ✓ G 14940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 4 Rose St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 4 Rose St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary LosKoX LOSKOT ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-1156

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-08

8. AGE: Years 35 | Months 11 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Wrapper

11. Industry or business Nat'l Pol. Bottling Co

FATHER
12. Name Clemens LosKoX
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Lena
15. Birthplace Czechoslovakia

16 (a) Informant Parents.
(b) Address 703 4 Rose St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-44 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Balto Md

18 (a) Funeral director Charles E Schumacher
(b) Address 2601 E Madison St

19 (a) MAR 10 1944 (Date) Registrar
Hospital for Milliners, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944, at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1944, to March 7 1944 and that I last saw h[illegible] alive on March 7 1944.

Immediate cause of death

Acute Cardiac Dilatation — Duration 3/6/44

Due to Lobar Pneumonia — 3/1/44

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J Brosnan M. D.
Address 801 4 Kenwood Ave Date signed 3/9/44

G 14941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14941 Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 N. Patterson Pk. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Stephen A. Pretl, Sr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Anna (nee Hubka)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1889

8. AGE: Years	Months	Days	If less than one day
55 yrs.	-	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Anthony Pretl
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Marie Cermak
15. Birthplace Czechoslovakia

16 (a) Informant Wife
(b) Address 903 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) ..... (b) ..... (Registrar)

MAR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-44 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23-44 to 3-7-44 and that I last saw h[illegible] alive on 3-7-44

Immediate cause of death: Coronary occlusion — Duration 9 min.
Due to: arteriosclerosis
Due to: Salem's
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Pretl
Address 600 Mathews Ave. Date 3-8-44 M. D.

G 14942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

V G 14942

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1106 E. Pratt St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1106 E. Pratt St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Bichanick or Maria Bicanic

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Steve Bichanick

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Not known ?

8. AGE: Years About 60 | Months | Days | If less than one day: hr. min.

9. Birthplace Russian (Europe) (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name ?

13. Birthplace Russian

14. Maiden Name ?

15. Birthplace Russian

16 (a) Informant Mr. Steve Bichanick

(b) Address 1106 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar-11-44 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Russian Location Anne Arundel County

18 (a) Funeral director John A. Gretlianglos Jr

(b) Address 423 S. Paca St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March-8- 1944. at 12 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-14-1944. to Mch-8-1944. and that I last saw h[er] alive on Mch-7-1944.

Immediate cause of death Myocardial-hemorrhagic cirrhosis

Duration About 1 yr 3 mos

Due to Chronic asthmatic bronchitis

Due to

Other Conditions - chronic nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herman Seidel M. D.

Address 2404 Eutaw Pl. Date signed 3/9/44

G 14943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G 14943 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. George Monroe

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-4934

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-1880

8. AGE: Years	Months	Days	If less than one day
63	8	4	hr. min.

9. Birthplace Charles Co Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Geo Monroe
13. Birthplace Md

MOTHER
14. Maiden Name Louise ?
15. Birthplace Md

16 (a) Informant Annie Monroe
(b) Address 620 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 12 44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Anne Arundel Co Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave Thursday 2 P Telephone

19 (a) MAR 10 1944 (Date received by registrar) Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 8 1944, at 1:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1944, to Mar 8 1944, and that I last saw h[illegible] alive on Mar 5 1944.

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Uremia

Due to Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert R. Cofaro M. D.
Address 822 N. Broadway Date signed 3/9/44

G 14944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14944 / 89a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Chary (Cherry)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace Washington, N. C (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Isaac Grimes
13. Birthplace N.C.

MOTHER 14. Maiden Name Etta Cherry
15. Birthplace N. C

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Boyd St Lexington

19 (a) (Date received by registrar) MAR 10 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

05

20. DATE OF DEATH March 5 1944 at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4 1944 to Mar 5 1944 and that I last saw him alive on Mar. 5 1944.

Immediate cause of death generalized convulsions
Due to L. lateral + L. cavernous sinus thrombosis + pneumococcal meningitis
Due to (type 4) and L. otitis media
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: infected cells in left petrous temporal
of autopsy: not reported

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John K. Birmingham M. D.
Address JHH Date signed 3-5

G 14945 G 14945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92C

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospital 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Franklin D.R. Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-37

8. AGE: Years	Months	Days	If less than one day
7	1	16	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

MOTHER / FATHER
12. Name James Young
13. Birthplace S.C.
14. Maiden Name Pauline Molley
15. Birthplace S.C.

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bank Lane

19 MAR 10 1944 (Date received by Local Registrar) (Signature) Huntington for Hillcrest Funeral Home

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 6 1944 to Mar 8 1944 and that I last saw him alive on Mar 8 1944

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic myocarditis, Mitral + aortic insufficiency	1 mo
Due to Rheumatic fever	2 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harriet G. Guild
Address Johns Hopkins Hosp. Date signed 3/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14946
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 243 N. Gilmore (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Monroe Squire

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1938

8. AGE: Years 5 | Months 7 | Days 15 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Squire
13. Birthplace N.C.

MOTHER
14. Maiden Name Mattie Monroe
15. Birthplace Dunbar - S.C.

16 (a) Informant Joseph Squire
(b) Address 243 N. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 10, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) Date received by Registrar MAR 10 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944 at 1 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1944 to March 7 1944 and that I last saw h[illegible] alive on March 7 1944.

Immediate cause of death: Meningococcic Meningitis — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 3-7-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

O 14947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14947 Registered No. 112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Veronica Reeder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1943

8. AGE: Years 8 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Reeder
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Gwendolyn Stewart
15. Birthplace Baltimore, Md.

16 (a) Informant Gwendolyn Reeder
(b) Address 528 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 926 N. Schroeder St.

19 (a) (Date received by registrar) (b) Registrar

MAR 10 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1944, at 10:28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1944, to March 7 1944, and that I last saw her alive on Mar. 7 1944.

Immediate cause of death
1. Malnutrition
2. Bronchial Asthma
Due to
Due to
Other Conditions Allergic Dermatitis
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. H. Barnett M. D.
Address Provident Hospital Date signed 3/8/44

14948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G 14948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1546 Wilkens Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1546 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Theresa M Tormey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Charles B
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1863

8. AGE: Years	Months	Days	If less than one day
80	2	22	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name	Frederick Lears
FATHER 13. Birthplace	Germany
MOTHER 14. Maiden Name	Wilhelmina Baier
MOTHER 15. Birthplace	Germany

16 (a) Informant Walter Tormey
(b) Address 1846 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-44 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Balto Md

18 (a) Funeral director George A Foley
(b) Address Fulton & Forrest

19 (a) MAR 10 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944, at 1:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert La Fratona M.D. Medical Examiner.
Date signed Mar. 9 1944

G 14949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 140C

G 14949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35 S. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J Bunford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jarvis A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 25 1914

8. AGE: Years 29 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ernest E Oakes
13. Birthplace Maine

MOTHER
14. Maiden Name Mary Schwartz
15. Birthplace Maryland

16 (a) Informant Jarvis A Bunford
(b) Address 35 S Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director George A Farley
(b) Address Fulton & Gaynell

19 (a) MAR 10 1944 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 11:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized peritonitis

Due to Self. induced abortion

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 9 1944

VS 151

G 14950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 14950 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lanvale Sts
(c) Hospital or institution: Mercy Hosp 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 E 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Gunse

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1944

8. AGE: Years	Months	Days	If less than one day
0	6	2	hr min

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Stuart Gunse
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Richardson
15. Birthplace Md.

16 (a) Informant Mrs Catherine Gunse
(b) Address 301 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto Md

18 (a) Funeral director George A. Forbes
(b) Address Fayette & Fulton

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 7, 1944, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 6, 1944 to Mar 7, 1944, and that I last saw him alive on Mar 7, 1944

Immediate cause of death	Duration
Resp. Failure	
Due to acute Dehydration	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C B Tunney M. D.
Address Mercy Hosp Date signed 3/7/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

H49958 14951 G 14951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 D

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

14-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 1811 Brunt (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Roger Berman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5-26-99

8. AGE: Years	Months	Days	If less than one day
44	9	12	hr. ..... min.

9. Birthplace VA (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Isaac Berman

13. Birthplace VA

MOTHER

14. Maiden Name Susan

15. Birthplace VA

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. B. Kelso

(b) Address 1303 Pressman St

19 (a) MAR 10 1944 (b) .....

(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 8 1944, at 10 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1944 to MAR 8 1944, and that I last saw him alive on MAR 8 1944.

	Duration
Immediate cause of death Respiratory Failure	
Due to ? Periarteritis Nodosa ? syphilitic arteritis	
Due to	
Other Conditions Hypertensive cardiovascular disease & uremia. (Include pregnancy within 3 months of death)	

Date of operation .....

Major findings of operation: .....

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

Means of injury .....

23. Signature Abraham Levenson

Address J. Hopkins Date signed 3-8

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 14952

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Orleans St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Clinton T. Cittings

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
---	714-03-4009	Male	White	Married

6 (b) Name of husband or wife Leona Gittings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1896

8. AGE: Years	Months	Days	If less than one day
47	4	23	hr. min

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business R.R. Express Co.

FATHER
12. Name Columbus Gittings
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Grimes
15. Birthplace Md.

16 (a) Informant Mrs. Leona Gittings
(b) Address 2202 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 13/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md.

18 (a) Funeral director Philip Sherry Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8/44 19 . at 4.30 A M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held [illegible] thereon (Autopsy or Inquiry) and from the evidence obtained by said [illegible] (Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

Immediate cause of death	Duration
Pontine Hemorrhage, Hypertension	
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner
Date signed 3-8-44

VS 6

G 14953

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14953 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 N appleton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL DUGAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Martha —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Junk Dealer

11. Industry or business

FATHER 12. Name David Dugan

13. Birthplace Russia

MOTHER 14. Maiden Name Sprain —

15. Birthplace Russia

16 (a) Informant: Mrs. Sol Caplan

(b) Address 1908 Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt. Carmel

Location O'Donnel St

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto. St

19 (a) (Signature of registrar) (b) Wm. J. Williams M.D. Registrar

MAR 10 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 10:45 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1944 to 3-8 1944 and that I last saw h[illegible] alive on 3-8 1944.

Immediate cause of death

Cerebral thrombosis

Due to Diabetic gangrene

Due to Diabetes mellitus.

Other Conditions Hypertension cardiovascular disease

(Include pregnancy within 3 months of death)

Date of operation 3-8 44

Major findings of operation: diabetic gangrene of r. leg

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. M. Friedman

Address West Balt. Gen. Hosp. Signed 3/9/44 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4495794954 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 24954

CERTIFICATE OF DEATH

1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA (b) County
(c) City or town Quakertown (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. 3 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet B Cohn
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Aaron
6 (c) If alive, give age: 30 years
7. Birth date of deceased (mo., day, yr.): 3 - 18 - 17
8. AGE: Years: 26 27 | Months: 11 | Days: 21 | If less than one day: hr. min.
9. Birthplace: VA (Town, county, and state)
10. Usual Occupation: House Wife
11. Industry or business

FATHER
12. Name: Michael Fenger
13. Birthplace: D. C.

MOTHER
14. Maiden Name: Mary Browdy
15. Birthplace: N.Y.

16 (a) Informant: Records
(b) Address: J.H. Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location

18 (a) Funeral director: Jack Peins Inc
(b) Address: 1439 E. Balto. St

19 (a) MAR 10 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAR 9 1944. at 900 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1944. to MAR 9 1944. and that I last saw her alive on MAR 9 1944.

Immediate cause of death: Cardiac Failure — Duration: 5 yrs.
Due to: Hypertension
Due to: Chronic Glomerulo-nephritis
Other Conditions: ? Syphilis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm. S. Sprunt M.D.
Address: Johns Hopkins Hospital Date signed: 3-10-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct. Age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

4955 Martha Chase

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 14955

CERTIFICATE OF DEATH

830

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N Carlin St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Martha Chase

If U. S. Veteran specify WAR

(a) Residence: No. 411 N Carlin St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) July 18, 1895

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	8	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) ~~Dumb Barnes~~ 411 N Carlin St.

17. INFORMANT Paul Barnes

(Address) 411 N Carlin St.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Calvary Date 3/12/— 19 44

19. UNDERTAKER Mrs Ida Bailey

(Address) 1819 Jefferson St.

20. FILED MAR 10 1944 19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 3/7/44. 19

22. I HEREBY CERTIFY, That I attended deceased from March 5 19 44 to March 7 19 44

I last saw h— alive on March 7 19 44 Death is said to have occurred on the date stated above, at 5:10 P.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Apoplexy	3 day
Other contributory causes of importance: Hypertension	

Was an operation performed? No Date of

For what disease or injury? None

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24a. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Bernard Harris M.D.

(Address) 1701 N Carlin St

OCCUPATION is very important. See instructions on back of certificate.

VS 5

14956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 746

G 14956
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Square Hospital
(c) Hospital or institution: Eutaw St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 180 E. Main St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Leroy Shearer

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Ethel B. Shearer
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) July 18, 1898

8. AGE: Years	Months	Days	If less than one day
45	7	21	hr. min.

9. Birthplace Glenville, Pa. (Town, county, and state)
10. Usual Occupation Dairy farms supervisor
11. Industry or business Balto. City health dept.

FATHER
12. Name Henry Shearer
13. Birthplace Penn.

MOTHER
14. Maiden Name Gertrude Allough
15. Birthplace Penn.

16 (a) Informant Mrs. Leroy C. Shearer
(b) Address 180 E. Main St. Cor. Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 13 (day) 44 (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Jos. E. Meyers, Jr.
(b) Address Westminster, Md.

19 (Date received by registrar) MAR 10 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9-44 19 , at 11:49 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19-44 19 to 3-9-44 19 , and that I last saw him alive on 3-9-44 19 .

Immediate cause of death: Acute mic Myeloid Leukemia — Duration: 5 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Chronic Myeloid Leukemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gerlong Glenck M. D.
Address Franklin Square Hosp. Date signed 3/9/44 M. D.

VS 2

4957
JL - 88087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

G 14957
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 13
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
William Verill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1926

8. AGE: Years 17 | Months 4 | Days 26 | If less than one day: hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name William Verill
13. Birthplace Maine

MOTHER
14. Maiden Name Alice Mills
15. Birthplace Mass.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Parkville

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St Paul St

MAR 10 1944
(Date received by Registrar)

(Signature) for Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1944 at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1943 to 3/9 1944
and that I last saw him alive on 3/9 1944

Immediate cause of death Pneumonia — Duration

Due to Pulmonary T.B.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia Extensive pulmonary T.B.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Acton, M.D.

Address B. C. H. Date signed 3/10/44 M.D.

VS 180

G 14958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 14958

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Chylinski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis Chylinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Jacob Damitz
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Maldoni
15. Birthplace Poland

16 (a) Informant Rev. Stephen Chylinski
(b) Address 4408 Liberty Hts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 13/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) (Date registered) (b) Huntingtown Williamsport

MAR 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to March 8 1944, and that I last saw him alive on March 8 1944.

Immediate cause of death Arteriosclerotic C.V. Disease — Duration 1941
Diabetes Mellitus — 3 yrs
Due to Improved Factors — 6 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eastheimer M. D.
Address 842 S. Eastern Ave. Date signed 3-10-44

G 14959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G 14959 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 436 S. Patterson Pk. Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 436 S. Patterson Pk. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin C. Kolodziejski

3 (b) If veteran, name war

3 (c) Social Security Account No. 218 12 8950

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1923

8. AGE: Years	Months	Days	If less than one day
21	-	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Asst. Coordinator
11. Industry or business

FATHER
12. Name Roleslaw Kolodziejski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Klesczewska
15. Birthplace Pa.

16 (a) Informant Frances Kolodziejski
(b) Address 436. S. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 11/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ogazinski
(b) Address 1930 Eastern Ave.

19 (a) (Date rec'd by Registrar) (b) Hunter for Wilson, M.D.

MAR 10 1944

VS 12a

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 11 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 6 19 44 to Mar 8 19 44 and that I last saw h[illegible] alive on Mar 8 19 44.

Immediate cause of death: Brain tumor, Cyst (Probably malignant) glioma — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation May 4 & 9 1944
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. C. Lilly M. D.
Address 432 S Patterson Pk Date signed 3/9/44

correct [illegible] to [illegible] Registry.

G 14960 ✓ G 14960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 32a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 459 Yale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 459 Yale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Farnia E. Roberts

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John W.

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Oct. 1879

8. AGE: Years 64 | Months 4 | Days | If less than one day: hr. | min.

9. Birthplace Whitehall Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name Edw. H. Sipes
13. Birthplace Whitehall Md

MOTHER
14. Maiden Name Mary E. Gibbs
15. Birthplace Md

16 (a) Informant Mrs Margt. McComas
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Gorsuch Ave Road.

18 (a) Funeral director John G. Hogan
(b) Address 8000 Baltimore St

19 (a) MAR 10 1944 (b) (Date received by registrar) Thomas for William Peregoy, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1944 to March 8 1944, and that I last saw h(er) alive on March 8 1944

Immediate cause of death: Cerebral Hemmorhage — Duration: 5 hrs

Due to

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M Collins M. D.
Address 3341 Frederick Ave Date signed 3-10-44

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 14961 ✓ G 14961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 7 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wyman Park Apartments 49th & Beech (Descriptive location)
(e) Citizen of foreign country? None (Yes or No)
If yes, name country .....

3 (a) FULL NAME Miss Minnie E. Simpson (Mrs. Minnie Ellsworth Simpson)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 27 - 1860

8. AGE: Years 83 | Months 8 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation ✓
11. Industry or business ✓

FATHER
12. Name Benjamin L. Simpson
13. Birthplace Prince George Co., Md

MOTHER
14. Maiden Name Sallie Tolliti Waters
15. Birthplace Snow Hill Md.

16 (a) Informant Home for Incurables
(b) Address 700 W. 40th St. pm 14

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery or crematory Congressional Cem.
Location Washington, D. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 10 1944 Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 10 1944 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1940, to March 10 1944, and that I last saw her alive on 3/9 1944.

Immediate cause of death: Cerebral Vascular Accident — Duration 3/3/44 (3 days)
Due to Arteriosclerosis (Gen) Hypertension Cardio Vas Dis. — 15 yrs.
Due to Diabetes Mellitus — 15 yrs.
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature W. Brafton Hargrave M.D.
Address 214 Med. Arts Bldg. Date signed 3/10/44 (M D)

correct age in months, days if under 1 year

VS 3

G 14962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14962 Registered No. 138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5707 Smith
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5707 Smith (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine B. Jeter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Martin L
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 2-18-1894

8. AGE: Years	Months	Days	If less than one day: hr.	min.
49	8	21		

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

MOTHER / FATHER
12. Name John Auld
13. Birthplace
14. Maiden Name Elizabeth Pausch
15. Birthplace

16 (a) Informant Martin L. Jeter
(b) Address 5207 Smith

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/13/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leonard J. Funk
(b) Address 1918 Hanford Rd

19 (a) (Date received by registrar) MAR 10 1944 (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to 3-9 1944 and that I last saw her alive on 3-9 1944.

Immediate cause of death: For Advanced Pulmonary Tuberculosis — Duration: 5 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Cooper M. D.
Address 2107 Park Ave Date signed 3/10/44

PLEASE ... correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 14963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 14963

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2241 McElldery Street
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days 13

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2241 McElldery Street
(If rural, give location)
(e) Citizen of foreign country? No Ellery (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Jerome

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name August
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Berent
15. Birthplace Poland

16 (a) Informant Frances Jerome
(b) Address 2241 McElldery Street

17 (a) Burial (b) Date thereof 3-13-44
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson Street.

MAR 10 1944 (Date received by Registrar) (b) Waiting for Williams MF (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1944 to March 9 1944 and that I last saw h alive on March 8 1944

Immediate cause of death
Hypertensive C-V-R Disease
—Acute Cardiac Failure

Duration: 2 yrs. 3 hours

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D.
M. D.
Address 2432 Monument St
Signed 3/10/44

PLEASE WRITE correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 14964
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 1700 Bolton Street
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Bolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

14-1

3 (a) FULL NAME Page Mason Russell (PAGE MASON RUSSELL)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife E. Clifton Russell
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) July 6, 1877.

8. AGE: Years	Months	Days	If less than one day
66	8	3	hr. min.

9. Birthplace Fredericksburg, Virginia (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name William Roy Mason
13. Birthplace Fredericksburg, Va.

MOTHER
14. Maiden Name Susan Thornton Mason
15. Birthplace Fredericksburg Va.

16 (a) Informant Edgar M. Shutt
(b) Address Staunton, Va.

17 (a) Removal (b) Date thereof Mar 11 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Orange Va.

18 (a) Funeral director Henry H. Jenkins Sons Co
(b) Address McCulloh Orchard 16

19 MAR 11 1944 Huntington, West Va.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943, to 3/9 1944, and that I last saw her alive on 3/9 1944.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr
Due to Arterio Sclerosis Hypertension	Gradual
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Reedy M.D.
Address 140 3 Park Ave Date signed 3/10/44
Wm H. Moody

965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 83a

G 14965

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4904 Arabia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 64 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4904 Arabia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Merritt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Hearman C. Merritt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1878

8. AGE: Years	Months	Days	If less than one day
65	10	1	hr. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

FATHER
12. Name William P. Grooms
13. Birthplace Md.

MOTHER
14. Maiden Name Joanna Reddish
15. Birthplace Md.

16 (a) Informant Muriel M. Stanek
(b) Address 4904 Arabia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/43 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) 3-1-1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 9 1944 at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1942 to March 9 1944, and that I last saw her alive on March 8 1944.

Immediate cause of death: Cerebral Hemorrhage
Acute Bronchitis
Due to Arterial Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 Day, 3 weeks, 54 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Rosenberg M.D.
Address 2025 E North Ave Date signed 3/10/44

PLEASE write plainly with pen or pencil and make correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 14966 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-11

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. Bouldin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Charlestown Md. (Town, county, and state)

10. Usual Occupation Sheet Metal Worker (Ret.)

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Louis B. Bailey
(b) Address 4646 Walther Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery
Location

18 (a) Funeral director Wellwing Lodge Inc.
(b) Address 1211 St. Paul St.

19 (a) MAR 11 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944, at 7:50 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry L. Wollenweber M.D.
Medical Examiner.
Date signed March 10, 1944

For Dr. H. L. Wollenweber, by Howard J. Maddox, M.D.

VS 151

14967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

25

G 14967 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Ausquith Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winston Surley

3 (b) If veteran, name war

3 (c) Social Security Account No. Savage

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 14 - 1943

8. AGE: Years	Months	Days	If less than one day
	10	25	hr. min

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Benjamin Surley

13. Birthplace VA

MOTHER 14. Maiden Name Rosa Lee Vaughan

15. Birthplace VA

16 (a) Informant Rosa Lee Surley

(b) Address 1928 Ausquith St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 3 10 - 44 (month) (day) (year)

(c) Cemetery or crematory, Petersburg VA

Location Virginia

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E Preston St

19 (a) MAR 11 1944 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

for D.H.L. Macomber

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1944 at 6:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to Measles

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Henry L Wollenweber M.D. Medical Examiner.

Date signed 3-10-44

by Thomas J. Weedon, M.D.

G 14968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G 14968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 E Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hr 35 m
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Mt. Holly St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Murphy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/44

8. AGE: Years	Months	Days	If less than one day
			4 hr. 35 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph A. Murphy
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Kelly
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Joseph A. Murphy
(b) Address 409 Mt Holly Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd.

18 (a) Funeral director John Conway & Son
(b) Address 901 W Lanvale Street

19. (a) MAR 11 1944 (Date rec'd by registrar) (b) Hunting for Williamsport, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10/44 19 , at 4 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10-1944, to 3-10-1944, and that I last saw him alive on 3-10-44 19

Immediate cause of death: Hemorrhage from stomach ulcer - 24 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harris Neal
Address 1014 Reed St
Date signed 3/10/44 M. D.

G 14969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G 14969

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Hollins St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Rivers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Joseph C. Rivers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1878

8. AGE: Years	Months	Days	If less than one day
65	4	19	hr min

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew W Galen
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Joseph C. Rivers (husband)
(b) Address 927 Hollins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (Month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Fowler & Son
(b) Address 9003 Baltimore Blvd

19 (a) MAR 11 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 10 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1944, to 3-10 1944, and that I last saw her alive on 3-10 1944.

Immediate cause of death Cardiac failure — Duration

Due to Congestive heart failure

Due to c pulmonary edema

Other Conditions Ascites; peripheral edema

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Ozazewski M.D.
Address Mercy Hospital Date signed 3-10-44

G 14970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22a

G 14970 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 E. Chase Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d

(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 E. Chase (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Hayworth

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-5866

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Anna Hayworth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/12/91

8. AGE: Years	Months	Days	If less than one day
52	11	26 27	hr. min.

9. Birthplace Knoxville, Tenn. (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business Bethelhem Fairfield Shipyard

FATHER
12. Name Edward Hayworth
13. Birthplace Knoxville, Tenn.

MOTHER
14. Maiden Name Susie Hayworth ?
15. Birthplace Knoxville, Tenn.

16 (a) Informant Anna Hayworth
(b) Address 1618 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery
Location A.A., Co.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 9 1944, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1944 to Mar 9 1944 and that I last saw h— alive on Ma 9 1944.

Immediate cause of death	Duration
Acute Myocarditis	4 Days
Due to Lobar Pneumonia	5 days
Due to La Grippe	7 days

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Lloyd Berry M. D.
Address 1420 E. Chase Date signed 3-11-44

G 14971

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 14971

Registered No. 1226

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat 19-7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1866

8. AGE: Years	Months	Days	If less than one day
78	?	?	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Music Teacher

11. Industry or business

FATHER
12. Name Charles Dunn
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth M. McNally
15. Birthplace Unknown

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 13 44. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave., City

18 (a) Funeral director Stewart & Mountain Company
(b) Address 108 W. North Ave., City

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to March 11 1944, and that I last saw her alive on Mar. 11 1944.

Immediate cause of death	Duration
Intestinal Volvulus	2 days
Due to	
Due to	
Other Conditions: Prostatectomy Malignant	19 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel T. Clayman M. D.
Address 33 W. Franklin St. Date signed

G 14972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 14972 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4304 Parkwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Penn

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-0127

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances E.
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug 15-1886

8. AGE: Years	Months	Days	If less than one day
57	6	24	hr. min.

9. Birthplace Cumberland Md (Town, county, and state)
10. Usual Occupation Foreman (Bethlehem Steel)
11. Industry or business

FATHER
12. Name Samuel S. Penn
13. Birthplace Md

MOTHER
14. Maiden Name Nancy Talley
15. Birthplace Md.

16 (a) Informant Mrs Frances E. Penn
(b) Address 4304 Parkwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 13-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard Murtha
(b) Address 5305 Harford Rd

MAR 11 1944 (Date rec'd by registrar) Forrest H. Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 44 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 19 44 to March 9 19 44.
and that I last saw h alive on 3-9 19 44.

Immediate cause of death Bronchial Pneumonia — Duration 11 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Murtha
Address 5305 Belair Rd Date signed 3-10-44 M. D.

VS 150

G 14973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

G 14973 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 Mulberry Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Mulberry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Frederick Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	A. A.	Widowed

6 (b) Name of husband or wife Fannie Beatrice Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/6/1879

8. AGE: Years	Months	Days	If less than one day
64	9	1	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jerome Holmes
13. Birthplace Maryland

MOTHER
14. Maiden Name Christine ?
15. Birthplace Albany N. Y.

16 (a) Informant Mrs. Myrtle Wake (Daughter)
(b) Address 1627 Mulberry Stree

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie E. Williams
(b) Address 2229 N. Belvidere St.

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1944 at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1944, to 3/7 1944, and that I last saw him alive on 3/7 1944

Immediate cause of death	Duration
Pneumonia (Bronchial)	4 days
Due to La-Grippe	12 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carson C. Johnson
Address 1802 Penna Ave Date signed 3/8/44 M. D.

G 14974

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 14974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 663 Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1919

8. AGE: Years	Months	Days	If less than one day
24	9	3	hr. min.

9. Birthplace Rose Hill - N.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Squire Brown
13. Birthplace Rose Hill - N.C.

MOTHER
14. Maiden Name Ella Williams
15. Birthplace Rose Hill - N.C.

16 (a) Informant Mrs. William Brown
(b) Address 663 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-44 (month) (day) (year)
(c) Cemetery or crematory Warsaw N.C.
Location

18 (a) Funeral director Mr. Katey R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 11 1944 (Date rec'd by registrar) (b) Huntington Hill Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to hes death on the day stated above, and death in my opinion resulted from: natural causes ☑ or accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions Marked obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 9, 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14975 / 46E G 14975 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3608 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Lawrence Winters

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Mrs. Louise Winters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1868

8. AGE: Years	Months	Days	If less than one day
75	8	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Patrick Winters
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Mc Farlane
15. Birthplace Ireland

16 (a) Informant Mrs. Louise Winters
(b) Address 3608 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Baltimore Md

18 (a) Funeral director Miller Lawrence
(b) Address 1410 Liberty Heights Ave

19 (a) (b)
Date received MAR 11 1944 Registrar

Filed MAR 13 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944, at 8 57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1944, to March 10 1944, and that I last saw him alive on March 10 1944.

Immediate cause of death: Coronary Thrombosis — Duration

Due to Arteriosclerotic Heart condition

Due to

Other Conditions Adenocarcinoma of colon, descending - obstruction
(Include pregnancy within 3 months of death)

Date of operation 2/19/44; 3/8/44.

Major findings of operation: Carcinoma of colon - obstruction

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. L. Chieffelle M. D.
Address (Date signed)

CHIEFFELLE

G 14976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G 14976 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 717 N. Mount St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Emma Nicholas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	

6 (b) Name of husband or wife John

(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 3 30 1884

8. AGE: Years	Months	Days	If less than one day
59	11	8	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lewis Nelson

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name ? Long.

MOTHER 15. Birthplace Virginia

16 (a) Informant Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12, 1944 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn, Location Baltimore City

18 (a) Funeral director Joseph A. Bipely

(b) Address 4629 Mount Street

19 (a) MAR 11 1944 (Date rec'd by registrar) (b) Huntington Hall Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1944 to March 9 1944, and that I last saw her alive on March 8 1944

Immediate cause of death Cardiac Failure — Duration 8 wks.

Due to Hypertensive Cardio-vascular Disease

Due to

Other Conditions Hemangioma, Liver & Ascites. Obesity (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hemangioma Liver

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Roger B. Scott M. D.

Address Johns Hopkins Hosp. Date signed 3-9-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14977 / 1214 — G 14977 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Presstman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Presstman St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Sales

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Rena Sales
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22, 1891

8. AGE: Years	Months	Days	If less than one day
52	2	15	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Tavern
11. Industry or business

FATHER
12. Name Stephen Sales
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Rena Sales
(b) Address 1309 Presstman St

17 (a) Burial (b) Date thereof 3/13/44 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Aylburtus
Location Md

18 (a) Funeral director Geo. H. Kelbaugh
(b) Address 1303 Presstman St

19 (a) (Registrar's signature) (b) Huntington Williams Registrar

MAR 11 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 19xx, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1943 to Mar 8 19xx, and that I last saw him alive on Mar 8 19xx.

Immediate cause of death Cardio Vascular Renal Disease — Duration: 6 mo's

Due to

Due to Pulmonary Hemorrhage — Duration: 2 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Frey M. D.
Address 1927 Penna Ave Date signed 3/14/44

G 14978

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. G 14978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. d.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 549 N. Biddle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. ? 1911

8. AGE: Years	Months	Days	If less than one day
32	4	—	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation No occupation

11. Industry or business —

FATHER 12. Name Saudie Johnson
13. Birthplace Virginia

MOTHER 14. Maiden Name Nellie Nickins
15. Birthplace Virginia

16 (a) Informant Rebecca Taylor
(b) Address 1351 N. Carey st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/44 (month) (day) (year)
(c) Cemetery or crematory Lancaster
Location Lancaster Co., Pa.

18 (a) Funeral director Geo. W. Nelson
(b) Address 1303 Preastman St

19 (a) MAR 11 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1944, at 12:30 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions Acute Congestive Cardiac Failure

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 3-10-44.

VS 151

G 14979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178c

Registered No. G 14979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 W. Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Simmons

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13-41

8. AGE: Years	Months	Days	If less than one day
2	6	26	hr. min.

9. Birthplace Summerville, S.C. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Auri C. Simmons.
13. Birthplace S.C.

MOTHER
14. Maiden Name Alice Sinkler
15. Birthplace S.C.

16 (a) Informant Auri C. Simmons
(b) Address 212 W. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 12-44 (month) (day) (year)
(c) Cemetery or crematory Summerville
Location South Carolina

18 (a) Funeral director James A. Hayes
(b) Address 1142 W. Pratt St

19 (a) MAR 11 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944, at 12 noon M

21. I certify that I took charge of the remains described above, held an ____ thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to Carbon Monoxide

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 23/1
(a) Date of injury March 9, 1944 11:40 A M
(b) Where did injury occur? 212 W. Hamburg St
(c) Did injury occur at home, on farm, industrial place, in public place? at home (While at work?) (Specify)
(d) Means of injury Suffocation

23. Signature Henry L. Wollemweber M.D.
Medical Examiner.
Date signed March 10, 1944

For Dr. L. Wollemweber, by Howard J. Walker, M.D.

G 14980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164E

Registered No. G 14980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Kenny Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 654 N. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mathew Landigan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) About 1894

8. AGE: Years	Months	Days	If less than one day
About 50			hr. min.

9. Birthplace Troy N.Y. (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant None
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Rd.

18 (a) Funeral director R. Lee Odea
(b) Address 4644 York Rd

19 MAR 11 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944, at 11:15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 9, 1944 1:05 P M.
(b) Where did injury occur? B.O. Building
(c) Did injury occur at home, on farm, industrial place, or public place? Public While at work? No
(d) Means of injury Jumped from 12th Story window

23. Signature Robert Lee Gregg M.D.
Medical Examiner.
Date signed March 9, 1944

G 14981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 14981

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4203 Springdale Ave.

(c) Hospital or institution: Mrs. Lewis' Convalescent Home 28-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3108 Ferndale Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Margaret Rochester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Samuel Charles Rochester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1861

8. AGE: Years	Months	Days	If less than one day
82	7	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Robert Lusby

13. Birthplace ?

MOTHER

14. Maiden Name Mary Margaret Hoffman

15. Birthplace ?

16 (a) Informant Mrs. Ernest Pritchard

(b) Address 2926 Sylvan Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Edmondson Ave.

18 (a) Funeral director John O. Mitchell & Sons Inc.

(b) Address 1900 Eutaw Place

MAR 11 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944 at 7.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1944 to Mar. 9 1944, and that I last saw her alive on Mar. 8 1944.

Immediate cause of death	Duration
Cardio-vascular hypertensive disease	10 yr. +
Due to Chr. interstitial nephritis	10 yr. +
Due to Gangrene Thrombosis	1 day
Due to Grippe	5 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Leo Schlenger M.D.

Address 4600 Liberty Heights Ave. Date signed 3/13/44

By residence

G 14982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14982 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1142 E Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 E Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie White Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30/1893

8. AGE: Years 52 | Months 51 | Days 6 | If less than one day: hr. 8 min.

9. Birthplace Richmond Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Turner
13. Birthplace Va.

MOTHER
14. Maiden Name Martha King
15. Birthplace Va.

16 (a) Informant Mary Banks
(b) Address 1142 Lombard St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 11/44 (month) (day) (year)

(c) Cemetery or crematory
Location Richmond Virginia

18 (a) Funeral director Mrs. Rufus A. Elliott & Son
(b) Address 1129 N. Caroline Street.

19 (a) MAR 11 1944 (Date received by local registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8-1944 to 3-8-1944 and that I last saw her alive on 3-8-1944

Immediate cause of death: Apoplexy — Duration:

Due to Hypertension arteriosclerosis & cardiac renal failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R W Purcell M. D.

Address 1422 E. Chase Date signed 3-10-44

G 14983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G 14983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 N. Dallas St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day: hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Thompson
13. Birthplace S. C.

MOTHER
14. Maiden Name Georgeanna Carter
15. Birthplace S. C.

16 (a) Informant George Thompson
(b) Address 1301 Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Roberta A. Elliott Daughter
(b) Address 1124 N. Carolina St.

19 (a) Filed MAR 1 1944 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8-1944 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1944 to 3/8 1944
and that I last saw it alive on 3/8 1944

Immediate cause of death: Bronchio Pneumonia — Duration 10 days
Due to Pleurisy — 4 years
Due to Grippe
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. R. Blake M. D.
Address 1327 N. Carlton Ave. Signed 3/10/44

14984
449739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125a

G 14984

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del (b) County
(c) City or town Seaford (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 3 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Richardson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-21-23

8. AGE: Years 20 | Months 21 | Days 6 | If less than one day hr 19 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Orem Kelly
13. Birthplace Md

MOTHER
14. Maiden Name Winifred Rinsfield
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14 1944 (month) (day) (year)
(c) Cemetery or crematory Galestown Cem.
Location Galestown, Md

18 (a) Funeral director Graves or Bros
Address Preston, Md

19 (a) MAR 14 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1944, to March 10 1944, and that I last saw h[illegible] alive on March 10 1944

Immediate cause of death
Toxemia
Due to Subacute yellow Atrophy of liver
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 8-9 wks.

Date of operation March 2, 1944
Major findings of operation: Incised liver - biopsy - Subacute yellow atrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Johns Hopkins Hosp. Date signed 3/10/44

14985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 14985

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 Mosher St
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Mosher St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rebecca E. Hill

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife John E
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 14, 1893

8. AGE: Years	Months	Days	If less than one day
50	9	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Domestic

FATHER
12. Name Henry Roberts
13. Birthplace Va

MOTHER
14. Maiden Name Hester
15. Birthplace Va

16 (a) Informant John E. Hill Husband
(b) Address 1518 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A.County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 MAR 11 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8/44 19 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1944 to 3-8 19 44
and that I last saw h alive on 3-8 19 44

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hrs.
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. N. Pigott M.D.
Address 1536 W. Lanvale St. Date signed 3-9-44

G 14986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 a

Registrar's No. G 14986

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 N. Calvert St
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

15-9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Queen Anne Rd. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Austria

3 (a) FULL NAME Mrs. Wilhelmina Seipelt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widowed

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1866

8. AGE: Years	Months	Days	If less than one day
77	9	29	hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr. Henry Magnus
13. Birthplace Austria

MOTHER
14. Maiden Name ?
15. Birthplace Austria

16 (a) Informant Mr. Walter H. Seipelt
(b) Address 2500 Queen Anne Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/13/44 (month) (day) (year)
(c) Cemetery or crematory Frank Pond Crematory
Location Queens, N. Y.

18 (a) Funeral director Wm. J. Luckman & Son
(b) Address Balto., Md.

19 (a) MAR 11 1944 (Local registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1944, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Cardio-Vascular failure

Due to Cardio-Vascular-Renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Van Lill III M. D.
Address Union Memorial Hosp Date signed 3-11-44

G 14937 BALTIMORE CITY HEALTH DEPARTMENT G 14987

CERTIFICATE OF DEATH

Registered No. D-14987

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Caroline
(c) City or town Denton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Carl Hilton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced.
M	W	

6 (b) Name of husband or wife [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Elijah Hilton
13. Birthplace Md

MOTHER
14. Maiden Name Lillian Wampler
15. Birthplace Md

16 (a) Informant Hosp. Records.
(b) Address University Hosp.

17 (a) Burial (b) Date thereof 3/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Pikesville Md

18 (a) Funeral director Geo L Berger Jr
(b) Address 1512 Hollins St

19 Filed March 14 1944 Huntington Williams Registrar
(Filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1944, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1943 to Mar. 10 1944, and that I last saw him alive on 3/10 1944.

Immediate cause of death T Meningitis — Duration

Due to Gangrene left foot

Due to perforated appendicitis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Jan. 31, 1944
Major findings of operation: Gangrene Foot
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. A. Kemper M. D.
Address Univ. Hosp. Date signed 3/10/44

G 14988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G 14988

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1844 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Luella McCurdy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Samuel J. McCurdy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1875

8. AGE: Years	Months	Days	If less than one day
68	9	10	19 hr. min.

9. Birthplace Hagerstown Maryland (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles D Kauffman
13. Birthplace Lancaster, Pa.

MOTHER
14. Maiden Name Sarilla Cookerman
15. Birthplace Hagerstown, Md.

16 (a) Informant Miss Ruth McCurdy
(b) Address 1844 W. Baltimore St.

17 (a) Burial (b) Date thereof 3-13-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Catonsville Maryland

18 (a) Funeral director Young Bros
(b) Address 5005 Park Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1944 at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1944 to 3/10 1944 and that I last saw her alive on 3/10 1944

Immediate cause of death	Duration
Massive Pulmonary Atelectasis	1 hr.
Due to Bronchogenic Carcinoma	?
Due to	
Other Conditions Hemothorax, Rt.	2 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Symmond Rogers M.D.
Address Bon Secours Hosp Date signed 3/10/44

VS 3

G 14989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55D

G 14989 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Cecil
(c) City or town Port Deposit
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Calvert

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Doris Calvert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
29			hr. min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Emory Calvert
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name Mary Little
15. Birthplace Cecil Co. Md.

16 (a) Informant Wilbur Calvert
(b) Address Port Deposit, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7, 44. (month) (day) (year)
(c) Cemetery or crematory Hopewell
Location Port Deposit, Md.

18 (a) Funeral director W. C. Patterson & Son.
(b) Address Perryville, Md.

19 (a) 3/11/44 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 11 1944, at 3:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1944, to 3-11 1944, and that I last saw him alive on 3-11 3:30 P.M. 1944.

Immediate cause of death: Intracranial pressure

Due to: Nasal tumor & metastasis to brain.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Mildred Grogan M. D.
Address University Hospital Date signed 3/11/44

G 14990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106c

Registered No. G 5390

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 S. Caroy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Kivett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3 1941

8. AGE: Years	Months	Days	If less than one day
2	8	8	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Pearl Kivett
13. Birthplace

MOTHER
14. Maiden Name Edna Kivett Hussey
15. Birthplace North Carolina

16 (a) Informant Pearl E. Kivett
(b) Address 1207 S. Caroy St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year)
(c) Cemetery or crematory High Point N.C.
Location North Carolina

18 (a) Funeral director Williams & Mc Dowell
(b) Address 217 S. Paca St

19 (a) March 16 1944 (Filed by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1944, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1944, to 3/11 1944, and that I last saw him alive on 3/11 1944

Immediate cause of death: Acute laryngotracheobronchitis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3/11/44
Major findings of operation: Emergency tracheotomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Carl Myers M.D.
Address Md. Gen. Hosp. Date signed 3/14/44 M. D.

G 14991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 16681 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 Tinges Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Tinges Lane (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles D. Fuller

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Bannon
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1870 1860

8. AGE: Years 84 | Months 0 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired Stationary Engineer

11. Industry or business Balto. City

FATHER
12. Name Darrell Fuller
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Harry Fuller
(b) Address 3101 Tinges Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross A.A.
Location Annapolis Blvd. A.A.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) MAR 12 1944 (b) Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944, at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1939 to Mar 11 1944, and that I last saw h[illegible] alive on Feb 1944.

Immediate cause of death — Duration

Cardiac Insufficiency — ?

Due to Arteriosclerosis — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel L. Ruth, M.D.
Address 1761 E North Ave
Date signed 3/11/44

VS 150

G 14992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 14992

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2122 E. Cumberland St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2122 E. Cumberland St

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Bluma Rebecca Fishbein

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Nathan —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation H. Wife

11. Industry or business

MOTHER / FATHER

12. Name Morris McKernan

13. Birthplace Russia

14. Maiden Name Edith —

15. Birthplace Russia

16 (a) Informant Miss Fannye Fishbein

(b) Address 2122 E. Cumberland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-44 (month) (day) (year)

(c) Cemetery or crematory Lizedale

Location Phila. Rd.

18 (a) Funeral director Jacob Levin Sons

(b) Address 1439 E. Balto. St

19 (a) MAR 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944, at 8 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1944, to 3/11 1944, and that I last saw h[illegible] alive on 3/10 1944.

Immediate cause of death

acute Cardiac Dilation

Due to

Due to acute Coronary Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature S C Feldman M.D.

Address 1440 E Balto St Date signed 3/14/44

G 14993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

G 14993 ✓

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Permanent Pt. Rutland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2120 E. Balto St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irma Lesser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17 - 1929

8. AGE: Years	Months	Days	If less than one day: hr.	min.
15	—	23		

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation School student

11. Industry or business

FATHER

12. Name Wm Friedman

13. Birthplace Balto.

MOTHER

14. Maiden Name Sylvia Levin

15. Birthplace Balto.

16 (a) Informant Minnie Lesser

(b) Address 2120 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-44 (month) (day) (year)

(c) Cemetery or crematory Pikesdale

Location Pikesville Md.

18 (a) Funeral director Jacob Levin and

(b) Address 1439 E. Balto St

MAR 12 1944

19 (a) Harrington Williams, M.D. Registrar

(Date rec'd by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10 1944, at 4:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1944, to 3-10 1944, and that I last saw h[illegible] alive on 3-10 1944.

Immediate cause of death Intestinal Complication

Due to Anemia

Due to Ruptured duodenal ulcer

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 3-10-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 3-9-44 at 8 A.M.

(c) Where did injury occur? Balto. Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Fire from stove spread to dress

23. Signature Irving Schenker

Address Sinai Hospital Date signed 3-10-44 M. D.

For H. L. Bollinger M.D. - by Howard Jr Mallon M.D.

G 14994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14994

Registered No. 157a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5/6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Braddish (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby of Morris & Dorothy Arenberg.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1944

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morris Arenberg.
13. Birthplace Balto Md

MOTHER
14. Maiden Name Dorothy Silver
15. Birthplace Pittsburgh Pa.

16 (a) Informant Morris Arenberg.
(b) Address 1704 Braddish ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12/44 (month) (day) (year)
(c) Cemetery or crematory Helen Washington Blvd.
Location Washington Blvd.

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 W. North ave

19 (a) MAR 12 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11-44 19 . at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1944, to 3-11 1944, and that I last saw h alive on 3-11 1944

Immediate cause of death Prematurity (3 hrs.) | Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Hydrocephalus, Patent Interventricular [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond B. Stolberg M.D.
Address Sinai Hosp. Date signed 3-11-44

VS 150

G 14995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

✓ G 14995 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Roche

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Daniel

13. Birthplace

MOTHER 14. Maiden Name Elizabeth Coughlin

15. Birthplace

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 14, 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Winkfield

(b) Address 914 Hastings Building Annex, Baltimore, Md.

MAR 12 1944 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION 6 p. m.

20. DATE OF DEATH March 12 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944, to Mch 10 – 1944, and that I last saw him alive on Mch 10 – 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 months
Due to	
Due to Arterio Sclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.

Address 1631 E North Ave Date signed 3/10/44

G 14996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 14996

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7531 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7531 Harford Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Mann's

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife John Mann's
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) April 3rd 1871

8. AGE: Years	Months	Days	If less than one day
72 73	- 11	- 7	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Adam Lauterschlager
13. Birthplace Germany

MOTHER
14. Maiden Name Kares
15. Birthplace Germany

16 (a) Informant Mrs Geo Wm Schilling
(b) Address 3803 Fenchurch Rd Guilford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/44. (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem. Location Pikesville Md.

18 (a) Funeral director Milton Schilling
(b) Address Funeral Director, Mt. Washington, Md.

MAR 12 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10 1944 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14-1943 to 3-10-1944 and that I last saw h alive on 3-9-1944.

Immediate cause of death Uremia 2 mos. Duration 1 yr.
Cardiac Failure 1 yr.
Due to Hypertensive CVD. 5 yrs
Gen'l arteriosclerosis
Due to Diabetes mellitus 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 36 E. Madison St Date signed 3-11-44

G 14997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 14997 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Caradelton Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Chase (William)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1895 ~~Unknown~~

8. AGE: Years 48 | Months 4 | Days 27 | If less than one day: hr. min.

9. Birthplace md Anne Arundel (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name George W. Chase

13. Birthplace md

MOTHER — 14. Maiden Name Margaret Carberry

15. Birthplace md

16 (a) Informant Stanley Chase

(b) Address Pasadena md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location md

18 (a) Funeral director George H. Kelson

(b) Address 1303 Presstman St

19 (a) MAR 12 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10 1944, at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1944, to 3-10 1944, and that I last saw h[illegible] alive on 3-10 1944.

Immediate cause of death: Cerebro-vascular accident c respiratory failure

Duration:

Antecedent: Left hemiplegia resulting from the accident

Due to: Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Rozanski M. D.

Address Mercy Hospital Date signed 3-11-44

G 14998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 14998 Registered No. 121

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Light St.
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Edgemere (If outside city or town limits, write RURAL and give town)
(d) Street No. 4-3 Sycamore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Virginia Bedford

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Widowed

6 (b) Name of husband or wife Edward Bedford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1875

8. AGE: Years	Months	Days	If less than one day
69	1	9	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Alfred E. Smith
13. Birthplace md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Lenna Wilson
(b) Address 1130 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-44 (month) (day) (year)
(c) Cemetery or crematory Poplar Heights md
Location md

18 (a) Funeral director George A. Kelson
(b) Address 1303 Preestman St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

MAR 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1944 to March 11 1944 and that I last saw he r alive on March 10 1944.

Immediate cause of death Peritonitis

Due to Acute ruptured appendicitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 7, 1944

Major findings of operation: Same as above

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul A. Lukato M.D.
Address 1212 Light St Date signed 3/11/44

FS 144

G 14999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G 14999 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Sinai Hospital 15th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 40Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Presbury St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John D Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-4921

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Eleanor C. Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16. 1883

8. AGE: Years 60 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Phila. Penna, (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Liquor

FATHER 12. Name Thomas A. Mitchell
13. Birthplace Phila. Penna,

MOTHER 14. Maiden Name Jennie L. Davis,
15. Birthplace Phila. Penna,

16 (a) Informant Mrs Eleanor M. Bennett,
(b) Address 342 Westshire Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Co. Md.

18 (a) Funeral director Robert S. Little,
(b) Address 2700 Edmondson Ave.

19 MAR 21 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1944 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1944 to March 11 1944. and that I last saw him alive on March 11 1944.

Immediate cause of death	Duration
Left ventricular failure	
Due to Myocardial damage	
Due to Lobar pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Murray Weiner, M. D.
Address Sinai Hosp Date signed 3/14/44

G 15000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15000 Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 N Dallas St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1804 N Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E Murphy

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15. 1866

8. AGE: Years 77 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Foreman Railroad

11. Industry or business R R Co

MOTHER / FATHER

12. Name Unknown

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant Thomas Gummer

(b) Address 4812 Richard Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)

(c) Cemetery or crematory St Duncans

Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc

(b) Address 1217 E Cont St

MAR 12 1944 (Registered by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944, at 9:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1. 1943. to March 10 1944. and that I last saw h[im] alive on March 10 1944.

Immediate cause of death Chronic Nephritis

Due to Arteriosclerotic Cardio Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Bowles M. D.

Address 1224 E Madison Date signed 3-11-44

G 15001 AB-85180 6 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15001 Registered No. 137a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.-10days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5608 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christian Grose Or Christian Grass

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept-28-1875
8. AGE: Years 68 | Months 5 | Days 12 | If less than one day hr. min. 13
9. Birthplace Switzerland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Christian Grose
13. Birthplace Switzerland

MOTHER
14. Maiden Name Margaret Flesh (D)
15. Birthplace Switzerland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn M.E.
Location Woodlawn

18 (a) Funeral director Milburn Lodome
(b) Address 1217 E. Lond St

19 (a) (Date received by registrar) (b) Registrar
MAR 22 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11 1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1943 to 3-11 1944.
and that I last saw h alive on 3-11 1944.

Immediate cause of death — Duration

Uremia — 1 wk
Due to Urinary Retention — 1 wk
Due to Benign Prostatic Hypertrophy — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B Hess
Address Balto City Hosp Date signed 3-14-44

FILLING WRITING A CERTIFICATE, Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 15002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115C

G 15002 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 W. Franklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days) 1 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 W Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine A. O'Connell

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
— W	— NAE	F	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 30-1939

8. AGE: Years	Months	Days	If less than one day
4	6	12	hr. min.

9. Birthplace Hartford Conn (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Michael W. O'Connell
13. Birthplace Toronto Canada

MOTHER
14. Maiden Name Lucille Mascolo
15. Birthplace Conn.

16 (a) Informant Michael W. O'Connell
(b) Address 3509 W Franklin St

17 (a) Removal (b) Date thereof 3/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Benedicts Cem
Location Hartford Conn.

18 (a) Funeral director Wm Cook Jno.
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12- 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1944, to Mar 12 1944, and that I last saw her alive on Mar 11 1944.

Immediate cause of death: Acute cardiac failure — Duration: 1 day
Due to Post operative Tonsilectomy
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3-10-44
Major findings of operation: Chr. infected Tonsils & adenoids
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature — Fred T. Kyle M. D.
Address Medical Arts Bldg Date signed 3-13-44

VS 150

Please write plainly, with pen or pencil. Use no abbreviations. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G 15003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G 15003
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4.3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 S. East Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Kraft

3 (b) If veteran, name war 40

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Bella P. Kraft

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, y: April 4th 1886

8. AGE: Years 57 | Months 10 | Days 22 | If less than one day: hr min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Receiving Clerk

11. Industry or business Davidson Chemical Co.

12. Name of FATHER: Andrew J. Kraft

13. Birthplace Pa.

14. Maiden Name of MOTHER: Margaret E. Baker

15. Birthplace Pa

16 (a) Informant: Mrs Bella P. Kraft

(b) Address 234 S. East Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/14/44 (month) (day) (year)

(c) ~~Cemetery or crematory~~ Lorraine

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) 3 1944 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944 at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1943 to 3-11 1944 and that I last saw him alive on 3-11 1944

Immediate cause of death: Carcinoma of larynx & erosion & hemorrhage.

Duration: 4&3 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Tracheotomy 2-42

Major findings of operation: Biopsy — Carcinoma of Larynx

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz

Address St Josephs Hosp Date signed 3-13-44

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15004 G 15004

JL - 86868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92C

Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 E. 28th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Strasinger

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 215-05-3443

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna M. Strasinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1909

8. AGE: Years 34 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Spedden Shipbuilding Co.,

FATHER
12. Name William Strasinger
13. Birthplace Md.

MOTHER
14. Maiden Name Mamie Reilly
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 12 1944 (Date rec'd by registrar) (b) Huntington Hilliard Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11 1944, at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1944, to 3-11 1944, and that I last saw ~~was~~ alive on 3-11 1944.

Immediate cause of death

	Duration
Due to Septicemia	5 days
Due to Acute Pharyngitis	5 days
Due to	
Other Conditions Rheumatic Valvulitis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald A. Webb M. D.
Address Balt City Hosp Date signed 3-11-44

G 15005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15005 Registered No.

108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Walter Enson

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-6836

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Enson (now Seal)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1907

8. AGE: Years	Months	Days	If less than one day
36	7	17	hr. min.

9. Birthplace Cockeysville, Md. (Town, county, and state)
10. Usual Occupation Carpenter & Builder
11. Industry or business

FATHER
12. Name J. Irwin Enson
13. Birthplace Md. - Balto. Co.

MOTHER
14. Maiden Name Emma Elizabeth Enson
15. Birthplace Md. - Balto. Co.

16 (c) Informant Mrs. C. W. Enson
(b) Address Cockeysville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Black Rock
Location Butler, Md.

18 (a) Funeral director Landon M. Broyles
(b) Address Sparks, Md.

MAR 13 1944 Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1944, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1944 to 3/12 1944.
and that I last saw him alive on 3/12 1944.

Immediate cause of death	Duration
Uremia	
Due to Kidney blockage	
Due to	
Other Conditions Lobar Pneumonia - right Pericarditis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Haught M. D.
Address Univ. Hosp. Date signed 3/14/44

Please answer all questions. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the information supplied is complete and correct age is especially important.

15006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 15006

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2929 W. Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Schnur

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widower

6 (b) Name of husband or wife late Anne E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1868

8. AGE: Years	Months	Days	If less than one day
75	4	23	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City of Baltimore

FATHER
12. Name — Schnur
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Mrs. Mary E. Romaer
(b) Address 2929 W. Lanvale St

17 (a) Burial (b) Date thereof 3/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3800 Old Frederick Rd

18 (a) Funeral director Harry F. Weber
(b) Address 4101 E. Edmondson Ave

19 (a) MAR 12 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944 at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1943 to March 10 1944 and that I last saw him alive on Dec 20 1943

Immediate cause of death	Duration
Coronary thrombosis	1 hr.
Due to Coronary Sclerosis.	3 yrs.
Due to Arteriosclerotic Cardio Vascular Renal disease	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Bruneau M.D.
Address Medical Arts Bldg Date signed 3/11/44

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 15007
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution:
Univ. Hosp W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 Loretta St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH ROSS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	

6 (b) Name of husband or wife: Alonzo Ross
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) June 16, 1895

8. AGE: Years	Months	Days	If less than one day
48	8	23	____ hr. ____ min.

9. Birthplace Harrisville Md
(Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name John Brown
13. Birthplace Md

MOTHER
14. Maiden Name Mary Enolds
15. Birthplace Md

16 (a) Informant Alonzo Ross
(b) Address 1930 Loretta Ave.

17 (a) Burial (b) Date thereof 3/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Harrisville Cem.
Location Dorchester, County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

MAR 13 1944
(Date rec'd by registrar)
(b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 19 44 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 19 44 to 3/9 19 44 and that I last saw her alive on 3/9 19 44

Immediate cause of death	Duration
Contusion of chest accident	1 day
Due to	
Due to	
Other Conditions Carcinoma breast, right	

(Include pregnancy within 3 months of death)

Date of operation 3/7/44
Major findings of operation: Carc. breast
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Roderick Shipley M. D.
Address University Hospital Date signed 3-10-44
Baltimore, Md

VS 8

5008

JL - 86640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G 15008

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Huron St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Lee

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1930

8. AGE: Years	Months	Days	If less than one day
13	2	25 21	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Douglas Lee
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Carter
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) Date rec'd by registrar MAR 13 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1944 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944 to 3/8 1944 and that I last saw him alive on 3/8 1944

Immediate cause of death	Duration
Coronary Occlusion; Pulmonary Edema	3 hr.
Due to Rheumatic C.V.D.	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Mitral & aortic regurgitation
of autopsy: card. hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman M.D.
Address 19 CH Date signed 3/9

Cause of death is especially important. If you cannot obtain information from attending physician, please notify the Coroner promptly and report.

G 15009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15009 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 E. Madison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZA GAINES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1891

8. AGE: Years	Months	Days	If less than one day
52	11	9	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George McFagin
13. Birthplace N. C.

MOTHER
14. Maiden Name Susie Johnson
15. Birthplace N. C.

16 (a) Informant Mr. Walter Simon
(b) Address 735 Ajax St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) MAR 13 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Mar. 10, '44 19 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death: Bronchopneumonia and Pleurisy — Duration 1 week 3 wks
Due to: Colds & Exposure
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Blake M. D.
Address 327-4 Central Date signed 3/11/44

VS 150

correct age is especially important

G 15010

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 15010 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 W. Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY WATTS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1876

8. AGE: Years	Months	Days	If less than one day
67	11	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Samuel Watts
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Md.

16 (a) Informant Mrs Lucy Loving
(b) Address 1521 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by Registrar) MAR 13 1944 (b) Huntington Pollard, M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March 9, 1944, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944 to 3/9 1944.
and that I last saw him alive on 3/9 1944.

Immediate cause of death
Cardiac - Renal
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
10 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Pollard M.D.
Address 17 W. Pleasant Date signed 3/10/44

Correct age is especially important

G 15011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15011
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 N Streeper St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N Streeper (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank C Weinreich

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Susie Weinreich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24 1870

8. AGE: Years 74 | Months 1 | Days 15 | If less than one day hr. min. 6

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business Painter

FATHER 12. Name Frederick Weinreich
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Meelcke
15. Birthplace Germany

16 (a) Informant Mrs Amelia Bosack
(b) Address 1525 N Spring Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) 3-9-1944 (Date city or town registrar) (b) Huntington Millbourne, Md. (Signature of registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10/44 19 . at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1943 to March 10 1944, and that I last saw h[illegible] alive on March 10 1944.

Immediate cause of death
Cerebral Apoplexy — Duration 7 mos.
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm J Schmidt
Address 701 N. Kenwood Ave Date signed 3/9/44

15012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 15012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Belt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Belt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle K. Butler.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Herbert W.

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 9/11/1883.

8. AGE: Years 60 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thos. Johnson
13. Birthplace Md.

MOTHER 14. Maiden Name Stephanie Crawford
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1701 Belt St.

17 (a) S (Burial, cremation, or removal) (b) Date thereof 3-13-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Jos. L. McKendy
(b) Address 306 E. Fort Ave.

MAR 13 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to March 10 1944 and that I last saw h[illegible] alive on March 10 1944

Immediate cause of death Acute Dilatation of Heart & Odema of Lungs — Duration 24 hrs

Due to

Due to

Other Conditions Chronic Myocarditis 10 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Lichtenberg M. D.
Address 1724 Madison Ave Date signed 3/10-44

15013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 92a

G 15013 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or Institution: Mercy Hospital 17-5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 642 Perkins Avenue (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME JACK PRATT

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-0776

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Black	Separated

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1905

8. AGE: Years	Months	Days	If less than one day
38	11	25	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Alex Pratt

13. Birthplace N.C.

MOTHER 14. Maiden Name Betty Higgs

15. Birthplace N.C.

16 (a) Informant Venetta Haves (Stiefdau)

(b) Address 642 Perkins Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 13 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania ave

19 (a) [illegible] Huntington Williams, Mgr.

MAR 13 1944

VS 180

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1944, to 3-10 1944, and that I last saw h/m alive on 3-10 1944.

Immediate cause of death Cardiac failure — Duration

Due to Cardiac insufficiency

Mitral insufficiency

Due to

Other Conditions Edema

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John C. Orzgewski M. D.

Address Mercy Hosp. Date signed 3-10-44

G 15014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G 15014 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Chatham Rd.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Chatham Rd. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Poland

3 (a) FULL NAME Mrs. Jennie Berenholtz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Mr. Charles Berenholtz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec., 1873

8. AGE: Years	Months	Days	If less than one day
70 71	3	?	hr. min.

9. Birthplace Warsaw, Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Mr. Sol. Berenholtz
13. Birthplace Poland

MOTHER
14. Maiden Name Esther
15. Birthplace Palayst

16 (a) Informant Mr. Sol. Charles Berenholtz
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-44 (month) (day) (year)
(c) Cemetery or crematory Wicomico Memorial Park
Location Same

18 (a) Funeral director Jack Levin Inc.
(b) Address 1439 E. Baltimore St.

19 (a) (Signature of local registrar) (b) Registrar
MAR 13 1944
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944. at 1:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1944. to 3/12 1944. and that I last saw her alive on 3/12 1944.

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Diabetic Acidosis

Due to

Other Conditions Arterio-sclerotic heart disease. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Mumgaugh Jr. M. D.
Address 332 E. University Pkwy Date signed 3/12/44

correct age is extremely important

15015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G 15015
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Green St
(c) Hospital or institution:
University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Fremont Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abbie Gladden

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216 10 60 93

4. Sex M

5. Color or race B

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth Gladden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Poster

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Hester M. Ruth Gladden
(b) Address 608 N. Fremont Av

17 (a) (Burial, cremation, or removal) (b) Date thereof 3rd (month) 13th (day) 1944 (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Single Interment

18 (a) Funeral director A. Jones
(b) Address 111 S. Gilmor St

19 (a) MAR 13 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1944, to 3/8 1944, and that I last saw h[illegible] alive on 3/8 1944.

	Duration
Immediate cause of death Hypostatic Pneumonia	6 days
Due to Influenza	1 week
Due to Hypostatic Pneumonia	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy Hypostatic Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Kemp M. D.
Address Date signed 3/8

VS 8

G 15016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 928

✓ G 15016

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4804 Keswick Rd.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) abt. 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4804 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Lucretia Van Bibber Emory Sampson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	Female	White	Widow

6 (b) Name of husband or wife Frederick Sampson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1878

8. AGE: Years	Months	Days	If less than one day hr.	min.
65	2	17		

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Thos. Lane Emory
13. Birthplace Balto.-Md.

MOTHER
14. Maiden Name Mary Fulton
15. Birthplace Balto.-Md.

16 (a) Informant Miss Elizabeth N. Hanson (Niece)
(b) Address 4804 Keswick Rd.-Roland Pk.-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-44 (month) (day) (year)
(c) Cemetery or crematory St Johns - Waverly - Balto Md
Location

18 (a) Funeral director Sturbaker Memorial
(b) Address 1080 Hanson.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MAR 13 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1944, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1944, to March 10, 1944. and that I last saw him alive on March 7, 1944.

Immediate cause of death Arteriosclerotic heart disease with infarctions

Due to Arteriosclerosis

Due to —

Other Conditions Cerebral thrombosis with right hemiplegia
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: —

of autopsy: —

Duration
Unknown

Received Jan 7 44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Tilden Howard M. D.
Address 12 E. Eager St. Date signed March 13 '44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15017
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 N. Augusta Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 W. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NETTIE MAE DAVIS

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Norval F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1874

8. AGE: Years 69 | Months 3 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry C. Taylor
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Laura V. Allen
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Curtis F. Davis
(b) Address 1904 Harlem Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3/14/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Maryland

19 (a) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1944 to Mar. 11 1944 and that I last saw her alive on Mar. 10 1944

Immediate cause of death Coronary Thrombosis — Duration: 6 mon.

Due to arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Kupp, M.D.
Address 3030 Edmondson Ave. Date signed 3/17/44

G 15018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 G 15018 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1544 Carswell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1544 Carswell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY BIEMILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Matilda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1865

8. AGE: Years	Months	Days	If less than one day
78	6	0	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Water Dept. City Balto.

FATHER
12. Name John Biemiller
13. Birthplace Austria

MOTHER
14. Maiden Name Josephine Ferret
15. Birthplace Austria

16 (a) Informant Mrs. Matilda Biemiller
(b) Address 1544 Carswell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore
Registrar

19 (a) MAR 13 1944 (Must be filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1939 to Mch 10 1944 and that I last saw h wife alive on Mch 9 1944.

Immediate cause of death

Due to Hypertension Cerebral Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: 5 yrs

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nat J Thinger M. D.
Address 2700 Eutaw Pl Date signed March 12 1944

correct age is especially important. Physicians, please write the number of years, months, days and hours clearly and legibly.

G 15019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 15019 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Thomas Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice B. Helm

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1872

8. AGE: Years 71 | Months 10 | Days 1 | If less than one day: hr. min

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Boblit
13. Birthplace Williamsport, Pa.

MOTHER
14. Maiden Name Elizabeth Barber
15. Birthplace Chestnut Ridge, Md.

16 (a) Informant Mr. Louis M. Helm
(b) Address 1704 Thomas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 13 1944 (b)
(Date received by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944 at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 19 44 to 3/10 19 44, and that I last saw her alive on 3/10 19 44.

Immediate cause of death Congestive Heart Failure — Duration 3-4 [illegible]

Due to [illegible]

Due to Coronary artery sclerosis & occlusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: At coroner's autopsy

PHYSICIAN
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Baltimore

Address [illegible] Hospital Date signed 3/10/44

correct age is extremely important. If unknown, please state approximate age. Write plainly and legibly.

5620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63a

G 15020
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2323 Ivy Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 Ivy Ave.
(Print name of location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Crowner

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1871

8. AGE: Years 72 | Months 10 | Days - | If less than one day hr. min

9. Birthplace Anne Arundel Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry Kirby
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Rachel Crowner Roberts
(b) Address 2323 Ivy Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13, 1944 (month) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1681 Druid Hill Ave

19 MAR 13 1944
(Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 19 44 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 19 44 to 3/10 19 44.
and that I last saw h[illegible] alive on 3/10 19 44.

Immediate cause of death Cerebral Apoplexy
Duration

Due to Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. M. Roberts M. D.
Address 734 Dumont Ave Date signed

VS 150

5021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 108

G 15021 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 N. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1620 N. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME Nancy Carey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1884

8. AGE: Years 59 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Fedmorland Co. Va (town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant George D. Salter
(b) Address 1609 Druid Hill Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-13-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Embalmer (or undertaker)

MAR 13 1944
(Date Rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10-44 19 at 11:A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29-44 to 3-7-44 19, and that I last saw her alive on 3-7-44

Immediate cause of death Lobar Pneumonia — Duration Several days

Due to Capillary Bronchitis

Due to Hypostatic

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation V

Major findings of operation: V

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide V
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Hartsdale M. D.
Address 526 N. Carey St. Date signed 3/13/44

correct age is especially important. If impossible, please state approximate age and why.

G 15022 ✓ G 15022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 Fremont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Fremont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas R. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-092-067

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1907

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace St. Michaels, Md. (Town, county, and state)

10. Usual Occupation Dishwasher

11. Industry or business Boys & Girls Lunchroom

FATHER 12. Name Richard Johnson
13. Birthplace Maryland

MOTHER 14. Maiden Name Ellen Johnson
15. Birthplace Maryland

16 (a) Informant Ellen Johnson
(b) Address 313 E. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/44 (month) (day) (year)
(c) Cemetery or crematory Mrs. Calvary
Location

18 (a) Funeral director A. Holmes Hafer
(b) Address 9 E Lanvale St

19 (a) Date Received MAR 13 1944 By Registrar Hastings for Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1944 at 6 P. M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. (Medical Examiner)
per Robert Lee Graham M.D.
Date signed March 10 1944.

15023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 15023

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 Division St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Division St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Polson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Thomas Polson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Penn.
(Town, county, and state)

10. Usual Occupation Domestic
11. Industry or business Private

FATHER
12. Name Harrison Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Cookerson
15. Birthplace Md

16 (a) Informant Jennie Smith
(b) Address 1537 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (Registrar's signature) MAR 13 1944 Registrar
Huntington Hollins, M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7/44, 19 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/44 19 to 3/7/44 and that I last saw [illegible] alive on 3/44 19

Immediate cause of death: Bronchopneumonia — Duration 3 days
(a) [illegible]
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellen M. D.
Address 507 Madison Date 3/7/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

G 15024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15024 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Bush St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Bush St (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Charles F Fonty

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Dora M. Fonty
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 5 1893

8. AGE: Years	Months	Days	If less than one day hr.	min.
50	10	4		

9. Birthplace Baltimore. Md (Town, county and state)
10. Usual Occupation Automobile Mechanic
11. Industry or business

FATHER
12. Name Geo. H. Fonty
13. Birthplace Maryland

MOTHER
14. Maiden Name Lydia Erich
15. Birthplace Maryland

16 (a) Informant Mrs Dora M Fonty
(b) Address 1511 Bush St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 13/44 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Md

18 (a) Funeral director F. D. Kilpatrick & Son
(b) Address 300 Eutaw Place

19 (a) MAR 13 1944 (Date received by registrar) (b) 1944 Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 9 1944 at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1944 to 3/9 1944. and that I last saw him alive on 3/9 1944

Immediate cause of death	Duration
Acute Cardiac Failure	1da
Due to Coronary Disease	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. Lankau M. D.
Address 1511 Washington Blvd Date signed 3/10/44

VS 150

G 15025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G 15025 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2251 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Koerner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mamie M. Koerner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1875

8. AGE: Years 68 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Chemist

11. Industry or business self

FATHER
12. Name John Koerner
13. Birthplace —

MOTHER
14. Maiden Name Mary —
15. Birthplace —

16 (a) Informant Mrs. Mamie M. Koerner
(b) Address 2251 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 16/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Henry Stahl
(b) Address 2024 Eutaw St

19 (a) MAR 13 1944 (b) Registrar
Date received by registrar Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-44 1944, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1944, to 3-12 1944, and that I last saw h alive on 3-12 1944.

Immediate cause of death Cardiac failure

Due to Abnormality + debility;

Due to arteriosclerotic heart disease

Other Conditions Carcinoma of lungs (Include pregnancy within 3 months of death)

Date of operation 2-25-44

Major findings of operation: Carcinoma of lungs

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Myers M. D.
Address Sinai Hospital Date signed 3-14-44

G 15026 ✓ G 15026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Bradshaw
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Harris

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 6, 1879

8. AGE: Years 65 | Months 1 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Inn Keeper

11. Industry or business

FATHER
12. Name Robert Harris Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Meade
15. Birthplace Maryland

16 (a) Informant F. Garry Mettee
(b) Address 35-25 77th. St Jackson Heights Long Island N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15, 1944 (month) (day) (year)
(c) Cemetery or crematory National
Location Balto. Md.

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) Date received MAR 13 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944, at 3:15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Knatchbull M.D.
Medical Examiner.
Date signed March 12 1944

VS 151

G 15027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15027 Registered No. 830

Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 S. Collington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 S. Collington Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ANNA CHRISTINE MUELLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife August Mueller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1874

8. AGE: Years	Months	Days	If less than one day
70	--	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Frederick Wm. Burmeister
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Rebecca Raban
15. Birthplace Germany

16 (a) Informant Anna Rebecca Mueller
(b) Address 409 S. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)
(c) Cemetery or crematory St. Pauls 5th Ref.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 (a) [illegible] (b) Huntington Williams, M.D.

MAR 13 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944, at 8.07 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1942, to 3-10 1944, and that I last saw her alive on 3-10 1944.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	5 DAYS
Due to ARTERIOSCLEROSIS	2 YRS
HYPERTENSION	2 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James T Kavanagh M.D.
Address 3328 McFadden Ave. Date signed 3-11-44

15028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

G 15028
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Elliott St.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Elliott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Creech

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1942

8. AGE: Years	Months	Days	If less than one day: hr.	min.
1	6	18		

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Creech
13. Birthplace Cumberland Kentucky

MOTHER
14. Maiden Name Mary Foster
15. Birthplace Baltimore Md.

16 (a) Informant Mary Creech
(b) Address 3002 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) MAR 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1944 to 3/11 1944 and that I last saw h/ alive on 3/10 1944.

Immediate cause of death Pericardial Collapse — Duration

Due to Acute Bronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theodore F. Mendonsa M. D.
Address 1016 S. East Ave. Date signed 3/11/44

15029 M

G 15029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 749 S. Curley St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 749 S. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Frank Martin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day hr.	min.
74				

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location German Hill Rd.

18 (a) Funeral director John F. Duda
(b) Address 2429 Hudson St.

19 (a) MAR 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940. to March 1944. and that I last saw him alive on March 11 - 1944.

Immediate cause of death	Duration
Cardio-vascular renal disease	
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Zeller, M.D.
Address 2739 Eastern Ave Date signed 3/12/44

15030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15030 Registered No. 95c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hilken Ave
(c) Hospital or institution: St. Agnes Hosp 20th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Fulton Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Juliano Manelli

3 (b) If veteran, name war None

3 (c) Social Security Account No. 219-01-8423

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of ~~husband or~~ wife Maria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 26-1883

8. AGE: Years	Months	Days	If less than one day
60	5	14 15	hr. min

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Woman's Apparel

PARENTS

12. Name of father Bernard
13. Birthplace of father Italy
14. Maiden Name of mother ~~F. Chiarenda~~ FIORAVANTE
15. Birthplace of mother Italy

16 (a) Informant Son - Bernard
(b) Address 123 N. Fulton Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Marley St

19 (a) (Date rec'd by Local Registrar) (b) Registrar

MAR 13 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11-44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10-44 19 44 to 3-11 19 44 and that I last saw h/it alive on 3-11-44 19 44

Immediate cause of death Heart failure
Atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation / of autopsy: Enlarged heart, atherosclerosis, right heart failure

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Taffuci - Act M.D.
Address St Agnes Hosp Date signed 3/11/44 M. D.

G 15031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 15031 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Lemon St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Lemon St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ida Baxter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Mack Baxter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1899

8. AGE: Years 44 | Months 7 | Days 23 | If less than one day hr. min

9. Birthplace N. C.
(Town, County, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Davis
13. Birthplace Cameron N. C.

MOTHER
14. Maiden Name Susan Smith
15. Birthplace Cameron N. C.

16 (a) Informant John Davis
(b) Address 2269 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3229 N. Schroeder St.

19 MAR 13 1944 Interim for Williams, Mrs K R
(Date received by Registrar) (Signature of Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1944, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1943, to March 8 1944, and that I last saw her alive on March 8 1944.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to Alcoholism

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. S. Hamblen M. D.
Address 2041 Park Ave. Date signed March 13-44

G 15032

AB-86197

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30F

G 15032 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Maisel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Eggers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27-1944

8. AGE: Years	Months	Days	If less than one day
	1	41 12	hr min.

9. Birthplace Baltimore-Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Raymond Eggers
13. Birthplace Maryland

MOTHER
14. Maiden Name Rita Krause
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremation (b) Date thereof 3-10-44 at 9 M
(cremation, [illegible]) (month) (day) (year)
(c) [illegible]crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director Baltimore City Health Department
(b) Address
(c) [illegible]

MAR 13 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1944 at 6.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1944 to 3/7 1944.
and that I last saw h[illegible] alive on 3/7 1944

Immediate cause of death	Duration
Pneumonia	
Due to Congenital Lues	
Due to [illegible]	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl P. Kinney M. D.
Address B. C. H. Date signed 3/9/44

Coroner's or Medical Examiner's physicians: please write the cause of death clearly and legibly.

G 15033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G 15033 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 Burgundy St.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days) unk

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Burgundy St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME George Ward

3 (b) If veteran, name war: unk
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Widowed

6 (b) Name of husband or wife unknown
6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace Va.

16 (a) Informant Ernest Smither
(b) Address 424 Burgundy St

17 (a) Burial (b) Date thereof March 13, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Boyle
(b) Address 400 Mount Street

19 (a) Filed by registrar Hilliard Williams M.D. Registrar

MAR 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10/44 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1944 to 3/10/1944 and that I last saw h— alive on 3/9/ 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	2
Due to Arterio Sclerosis	2
Due to Chronic Nephritis	2yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jno Bosley M. D.
Address 519 N Carrollton Date signed 3/11/44

15034
ID - 86817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G 15034
Registered No.

Please write plainly, preferably with pen, and write cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Bank St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Mazalewski or Genevieve Mazalewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1928

8. AGE: Years	Months	Days	If less than one day
15	7	3	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vincent
13. Birthplace Poland

MOTHER
14. Maiden Name Anne Gibowicz
15. Birthplace Poland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof March 14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore

18 (a) Funeral director Fred W Oppenhold
(b) Address 1930 Edmondson Ave Baltimore, Md.

19 (a) MAR 13 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1944 at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1944 to 3/11 1944
and that I last saw h[illegible] alive on 3/11 1944.

Immediate cause of death Pulmonary infarcts ? Pneumonia, Viral

Duration 5 d.

Due to Pneum. C.M.D.

Due to

Other Conditions Pass. rheumatic pericarditis (?)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sergeran M.D.

Address B.C.H. Date signed 3/12

Local 15035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15035
Registered No.

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
Gen'l German Aged People Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Schuit.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: late Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29, 1862

8. AGE: Years 81 | Months 4 | Days 9 10 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Nikolas Schuit

13. Birthplace Germany

14. Maiden Name —

15. Birthplace Germany

16 (a) Informant Gen'l German Home
(b) Address 22 S. Athol Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd.

18 (a) Funeral director Harry A. Wilke
(b) Address 1016 Edmondson Ave.

19 (a) 1944 (Date of this registration) (b) Arthur Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944 at 10. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 3/44 19 to Mch. 9/44 19, and that I last saw h im alive on Mch. 9/44 19

Immediate cause of death — Duration

Proncho-Pneumonia — 6 days.

Due to

Due to

Other Conditions: Unknown.
Arterio-Sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Wade Okeefe M. D.
Address 933 Hanover Street Date signed Mch. 3/44.

VS 150

G 15036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157C

G 15036 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 Frederick Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Commers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11 44

8. AGE: Years | Months | Days | If less than one day hr. 1 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm. H. Commers

13. Birthplace W. Va.

MOTHER 14. Maiden Name Violet Collins

15. Birthplace Ohio

16 (a) Informant Susie Brown

(b) Address 1927 Frederick Ave

17 (a) Burial (b) Date thereof 3/13/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood

18 (a) Funeral director David H. Fizzle

(b) Address 401 E Edmondson Ave

19 1944 (Date received by registrar) (Signature of registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1944 at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1944 to 3/21 1944, and that I last saw h alive on 3/21/44 at 2 P.M. 1944

Immediate cause of death Anencephalic Monster — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Chester A. Tulenko M. D.

Address 2207 Druid Park Dr. Date signed 3/21/44

VS 280

450834
G 15037

BALTIMORE CITY HEALTH DEPARTMENT X G 15037
CERTIFICATE OF DEATH ✓ 54B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Hillside (If outside city or town limits, write RURAL and give town)
(d) Street No. 1458 Compton Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Schultz JR
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife IRENE
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) 2-10-94
8. AGE: Years 50 | Months 1 | Days 3 | If less than one day: hr. min.
9. Birthplace N.J. (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business

FATHER
12. Name Joseph Schultz
13. Birthplace N.Y.

MOTHER
14. Maiden Name EMMA Petch
15. Birthplace N Y

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem. Location Linwood, Md.
18 (a) Funeral director Edw. O. Mitchell & Sons
(b) Address 1900 Eutaw St.
19 (a) MAR 13 1944 (Date received by Registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 13 1944, at 2:35 A M
21. I certify that death occurred on the date above stated; that I attended deceased from MAR 11 1944 to MAR 13 1944, and that I last saw him alive on MAR 13 1944.

Immediate cause of death: Brain Tumor
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Brain Tumor - Astrocytoma

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Crawford Davis M. D.
Address Johns Hopkins Hosp. Date signed 3/13/44

C 15638

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

172 England

C 15028 (Registered No.)

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: S.S. Emperor
(a) State England (b) County Pleasure
(c) City or town London
(If outside city or town limits, write RURAL and give town)
(d) Street No. 44 Cornfield Rd
(If no street, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Cox

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	4

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Florence C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14 1908

8. AGE: Years	Months	Days	If less than one day
35	3	27	hr. min.

9. Birthplace England (Town, county and state)
10. Usual Occupation Naval Gunner
11. Industry or business H.M.S. British Navy

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Raymond Short
(b) Address British Navy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson Undertaking Co
(b) Address 1210 Pennsylvania Ave
(c) Thurlington Williams, M.D. Registrar

MAR 13 1944 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11- 1944, at 10 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-11-44 at 25/6 M.
(b) Where did injury occur? S.S. Emperor Planet
2400 Kawasaki Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public Establishment While at work? Yes
(d) Means of injury Fell down hatch 4 above deck

23. Signature Howard J. Moseley M.D.
Medical Examiner.
Date signed 3-11-44

G 15039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15039
Registered No.

M. - 86641

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town) Wetheredsville
(d) Street No. 5006 Wetheredsville Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Annie Townsend~~ Annie E. Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles M. Townsend

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~June 9 1860~~ July 22 1870

8. AGE: Years ~~74~~ 73 | Months 7 | Days 19 | If less than one day: hr. min.

9. Birthplace Md. Ellicott City (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name William P. Atkinson
13. Birthplace United States

MOTHER
14. Maiden Name Miss Calvin
15. Birthplace United States

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 4510 Liberty Heights Ave.

MAR 13 1944 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~3~~ 3/11 1944, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1944, to 3/11 1944 and that I last saw her alive on 3/4 1943.

Immediate cause of death Pernicious anemia: Anoxic-Anemia (?)

Duration: 3 /

Due to

Due to

Other Conditions A.S. C.V.D. & dropsy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seipman M. D.

Address BCH Date signed 3/12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

450819 40 — BALTIMORE CITY HEALTH DEPARTMENT — G 15040 (Registered No.)

CERTIFICATE OF DEATH 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 930 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Geneva Wilkerson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	black	baby

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1			hr min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Wilkerson
13. Birthplace Va.

MOTHER
14. Maiden Name Marian Faulkner
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County

18 (a) Funeral director Mrs. Ethel A. Elliott & Dgt.
(b) Address 1129 N. Caroline St

19 (a) MAR 13 1944 Huntington Williams Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10 1944 to Mar. 11 1944 and that I last saw her alive on Mar. 11 1944.

Immediate cause of death Respiratory failure — Duration 4 days

Due to ? Pneumonia

Due to Measles

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp Date signed 3-11-44

(over)

C 15041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. C 15041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1824 Ashland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy Mills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1882

8. AGE: Years	Months	Days	If less than one day
61	6	11	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Irene Williams
(b) Address 1824 Ashland Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 3/44 (month) (day) (year)
(c) Cemetery or crematory
Location Littleton N. Carolina

18 (a) Funeral director Mrs Robert A. Elliott & Dgt
(b) Address 1324 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 13

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to March 11 1944 and that I last saw h[illegible] alive on March 10 1944.

Immediate cause of death Carcinoma Liver

Duration 6 mos

Due to

Due to

Other Conditions Severe Jaundice and Myocarditis, and Nephritis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph J. Young

Address 1424 E Monument Date signed 3/12/44 M. D.

VS 150

G 15042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 15042 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home + Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Chanler 17 3426 Et (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** (Springer) Mrs Elizabeth Hartmuth

3 (b) If veteran, name war No (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Springer (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1859

8. AGE: Years	Months	Days	If less than one day
84	3	27 28	hr min.

9. Birthplace Cincinnati Ohio (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Philip Hartmuth
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Martin
15. Birthplace Germany

16 (a) Informant John J Springer (son)
(b) Address Calvert Ridge Apts Chanler + 34th St Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar/14/44 (month) (day) (year)
(c) Cemetery or crematory Vine Street Hill
Location Cincinnati, Ohio

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave, City

19 (a) MAR 13 1944 (Date rec'd by registrar) Huntington Ind. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944 at 1.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1944 to March 11 1944, and that I last saw her alive on March 11 1944.

Immediate cause of death Pulmonary Edema — Duration 2 days
Due to Uremia — 8 days
Due to Arteriosclerotic Heart Disease — ?
Other Conditions Intertrochanteric Fracture of Neck of Left Femur — 71 days
(Include pregnancy within 3 months of death)

PHYSICIAN
Underline the cause to which death should be charged statistically.

Date of operation January 10, 1944
Major findings of operation: Intertrochanteric Fracture of Neck of Left Femur
of autopsy:

22. If death was due to external causes, fill in the following: 12/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Jan 7 1944 at 7.00 P M
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Painting at apartment While at work? No (Specify type of place)
(e) Means of injury Fall in pantry

23. Signature John M. Fuller M. D.
Address Church Home + Hosp. Baltimore, Md Date signed 3-11-44

W. L. Wollenweber M D Asst Medical Examiner

15043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. G 15043

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Owen F. Wagner

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 48 | Months | Days | If less than one day hr. min

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS M... MAR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 13 1944 (b) Huntington Williams
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27- 1944, at 1 05 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating Gas

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-27-44 at P. M.
(b) Where did injury occur? 1807 N. Calvert St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Open gas jet, admitted to mouth

23. Signature Howard J. Edwards M.D.
Medical Examiner.
Date signed 2-28-44

10786

15044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. C 15044

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5355 Denmore Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Charles Kolsey

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1914

8. AGE: Years	Months	Days	If less than one day
29	3	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Marshall A. Kolsey
13. Birthplace Frederick County, Md.

MOTHER
14. Maiden Name Lizzie Matthews
15. Birthplace Carroll County, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 1 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 13 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1944, at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1943, to Feb. 25 1944, and that I last saw him alive on Feb. 25 1944.

Immediate cause of death: Dislocation of 5th cervical vertebra
Due to: Execution by hanging
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. F. Karns, M. D.
Address Md. Pen. Hospital Date signed 2-25-44

VS 189

10.87

045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 15045

Registered No.

correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 103 N. Broadway St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balt.

(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 103 N. Broadway (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Vaughn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	C	

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1944

8. AGE: Years	Months	Days	If less than one day
			18 hr. 10 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Tuft Vaughn

13. Birthplace Ashland N.C.

MOTHER 14. Maiden Name Charlotte Boggs

15. Birthplace Washington Co. Va

16 (a) Informant Mother Mrs. Vaughn

(b) Address 103 N. Broadway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location JOHN HOPKINS MEDICAL SCHOOL MAR 13 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (Date rec'd by registrar) MAR 13 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1944 at 8 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12 1944 to Mar. 13 1944 and that I last saw h alive on Mar. 13 1944

Immediate cause of death Premature Birth (Unknown Cause) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ralph W. Pentlington M.D.

Address 424 N. Johnson St Date signed 3 M

VS 180

0-88

15046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15046
Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Pennsylvania Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Helen B. Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 9/12 | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 13 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (c) MAR 13 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1944 at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from; natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular, primary.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
for Medical Examiner.
Date signed 3-4-44.

0.85

VS 151

13047

G 15047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 482

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. M. Charles Nagengast

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1866

8. AGE	Years	Months	Days	If less than one day
	77	8	17 13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Religious

11. Industry or business Teacher

FATHER
12. Name John Nagengast
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Straub
15. Birthplace Germany

16 (a) Informant Sr. M. Stan. Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (b) Date thereof Mar 14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Notch Cliff
Location Glen Arm

18 (a) Funeral director Geo. M. Kane & Son
(b) Address 811 N Wolfe St

19 (a) MAR 13 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944, at 4.20PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to March 12 1944, and that I last saw her alive on March 10 1944.

Immediate cause of death: Carcinoma body of uterus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Turley M. D.
Address 1108 North Ave Date signed 3-13-44

G 15048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 15048 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Temple Gardens Apts 1007
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Gardens Apts 1007 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C Hoffberger

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-5804

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henrietta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1899

8. AGE: Years 44 | Months 7 | Days 22/23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Corp. Executive

FATHER
12. Name Charles Hoffberger
13. Birthplace Austria

MOTHER
14. Maiden Name Sarah Hollander
15. Birthplace Austria

16 (a) Informant Charles Hoffberger
(b) Address Temple Gardens Apts 1007

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (b)

(Date rec'd by registrar) Registrar

13 1944 Huntington Williams, M.R

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944 at 7.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1943 to March 1944, and that I last saw h.m. alive on March 12 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 1 day

Due to Hypertension — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1944 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frederick Leutz M. D.
Address Temple Gardens Apts Date signed 3/13-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15049 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Conway

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day hr.	min.
84				

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Nicholas
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Brofly
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Winkfield
(b) Address 914 Lanvale

19 (a) [illegible] Washington Ave

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944, at 6 p m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944, to Mch 11 1944, and that I last saw alive on Mch 11 1944.

Immediate cause of death	Duration
Cerebral Arterio Sclerosis	1 yr
Due to	
Due to	
Other Conditions Chronic Myocarditis	5 yr

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed 3/11/44

G 15050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 54a

G 15050 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 E. Hoffman street
(c) Hospital or Institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 E. Hoffman street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM DeSALES BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Rose A. Brown
6 (c) If alive, give age 41 years

7. Birth date of deceased mo., day, yr. Sept. 17, [illegible]

8. AGE: Years	Months	Days	If less than one day
53	5	26	hr min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business Fire Dept.

FATHER
12. Name William H. Brown
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah E. Campbell
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Rose A. Brown
(b) Address 1010 E. Hoffman street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans & Son
(b) Address 118 N. Mt. Royal Ave

19 (a) [illegible] Huntington Williams M.D.
(Date received by registrar) (Registrar)
MAR 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1944 at 8:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1943 to March 13 1944, and that I last saw him alive on 3/10 1944.

Immediate cause of death: Tumor ? Brain, Glioma Brain stem. (Malignant) — Duration: Oct 1943
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos Glennon
Address Patrol Hqrs. Date signed 3/13/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15051
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Washington
(c) City or town Hagerstown
(d) Street No. 607 Highland Way
(e) Citizen of foreign country? No. Yes or No?
If yes, name country

3 (a) FULL NAME Eva Mae Pearce.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Paul Pearce
6 (c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) 1906
8. AGE: Years 38 Months Days If less than one day hr min
9. Birthplace Md.
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Luther Francis
13. Birthplace

MOTHER
14. Maiden Name Lida Ball
15. Birthplace

16 (a) Informant Husband
(b) Address 607 Highland Way, Hagerstown
17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof March 15 (month) (day)
(c) Cemetery or crematory Potterstown Cemetery
Location Potterstown, Md. via
18 (a) Funeral director C. M. Richardson
(b) Address 205 N. Potomac St. Hagerstown
19 (a) (Signature and title)
(b) Hagerstown, Md.

MAR 13 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13-44 19 at 3:30 P.M.
21. I certify that death occurred on the date above stated, that I attended deceased from 3-7 1944, to 3-13 1944
and that I last saw her alive on 3-13 1944

	Duration
Immediate cause of death: Brain abscess	
Due to: Empyema	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
(f) Signature E. Hamilton Pearl, M.D. M.D.
Address Univ. Hosp. Date signed 3-13-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15053 Registered No.

Correct age is especially important—if unknown, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Glendale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Glendale
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Anna Margaret Vogtmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis G. Vogtmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17-1875

8. AGE: Years	Months	Days	If less than one day
68	4	25	hr. min

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Louis Vogtmann
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Henni
15. Birthplace Switzerland

16 (a) Informant Louis G. Vogtmann
(b) Address 3006 Glendale Ave.

17 (a) Burial (b) Date thereof Mar. 14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Edmondson Ave.

18 (a) Funeral director John R. Miller
(b) Address 2334 Jefferson Ave.

19 (a) Embalmer Huntington Williams (b) Registered

MAR 13 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 19 44 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1943, to 3/4 1944, and that I last saw h alive on 3/1 1944.

Immediate cause of death Hypertension
Cardio-Vascular
Renal

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lyle C. Bolley

Address 5705 Harford Rd. Date signed 3/11/44
M. D.

G 15053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15053

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7215 Plainveiw Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a. State Md. b. County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 7215 Plainveiw Ave.

(If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Annie Kriss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Anton Kriss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27-1870

8. AGE: Years	Months	Days	If less than one day
74	1	16	hr min

9. Birthplace Austria

(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Joseph Lokota

13. Birthplace Austria

MOTHER 14. Maiden Name Not Known

15. Birthplace Not Known

16 (a) Informant Anton Kriss

(b) Address 7215 Plainveiw Ave.

17 (a) Burial (b) Date thereof Mar. 16/44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Hill

Location Horner's Lane

18 (a) Funeral director John G. Miller

(b) Address 2934 Jefferson St.

19 (a) Date received by Registrar MAR 13 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944 at 330 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1944 to March 12 1944, and that I last saw h e alive on March 12 1944.

Immediate cause of death Cerebral Apoplexy

Duration 1 day

Due to Arterio-Sclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Leo M. Baumgardner M. D.

Address 3606 Date signed 3/13/44

15054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 127a

G 15054
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 N. Duke ave. Balto
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Andrew Muselin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1881

8. AGE: Years	Months	Days	If less than one day: hr	min
62 63	8	21		

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Watchman
11. Industry or business Restless Iron & Steel

FATHER
12. Name Joseph Muselin.
13. Birthplace Germany.

MOTHER
14. Maiden Name Wilhelmina Muselin
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Catherine Johnson
(b) Address 1535 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leonard J. Rucky
(b) Address 1305 Hanford Rd

19 (a) MAR 1 [illegible] Huntington Williams, M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1944 at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1944 to March 13 1944 and that I last saw him alive on March 12 1944.

Immediate cause of death Respiratory failure.

Due to Uremia

Due to Renal atrophy

Other Conditions Prostatic Hypertrophy

(Exclude pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Randall Ziegler M. D.
Address Mercy Hospital Date signed 3-13-44

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G-15055

D. - 86886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 D

Registered No. G-15055

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 14-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

a State Maryland b County

c City or town Baltimore
(If outside city or town limits, write RURAL and give town)

d Street No. 1736 McCulloh St.
(If rural give location)

e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Ashby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Zebedee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1897

8. AGE: Years	Months	Days	If less than one day
47	1	5	hr min

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Johnson

13. Birthplace ?

MOTHER 14. Maiden Name Carrie ?

15. Birthplace Md.

16 (a) Informant B. C. H Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Chas. Geo. A. Holland

(b) Address 1631 Druid Hill Ave

MAR 15 1944 Huntington Williams, M.D.

(Registrar's signature) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1944, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1944 to 3/11 1944, and that I last saw her alive on 3/4 1944.

Immediate cause of death Prob. Coronary Thrombosis.

Duration Immediate

Due to H.C.V.D.

Due to

Other Conditions Hypertension Encephalopathy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

b Date of occurrence at M

c Where did injury occur?
(City or town) (County) (State)

d Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

e Means of injury

23. Signature E. L. Seigman M. D.

Address 1314 Date signed 3/12

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

15056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

G 15056
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4110 NORFOLK AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State MD. b County
c City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
d Street No. 4110 NORFOLK AVE
(If rural give location)
e Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GAIL ARLENE HYMAN

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 29, 1943

8. AGE: Years | Months 3 | Days 2 | If less than one day 16 hr 14 min

9. Birthplace BALTO. MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name FRANK HYMAN
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name SYLVIA COOPER
15. Birthplace BALTO. MD

16 (a) Informant FATHER
(b) Address

17 (a) BURIAL (b) Date thereof 3-14-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WINDSOR MILL RD
Location WINDSOR MILL RD.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balt St

19 (a) MAR 14 1944 (b) Hunting for Hillman
(Date rec'd by registrar) Registrar

0

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13-44 19 at 2.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1943, to 3-13 1944, and that I last saw h[illegible] alive on 3-12 1944.

Immediate cause of death: Acute Laryngo-Tracheal-bronchitis — Duration: 3 days

Due to

Due to

Other Conditions PREMATURITY

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lucille Liberles
Address 1739 Eutaw pl. M D Date signed 3-13-44

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46R

Registered No. G 15057

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Woodhaven Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 32 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Woodhaven Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Krauss

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-6126

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frieda Krauss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16

8. AGE: Years 50 | Months | Days | If less than one day hr min

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fisher —
13. Birthplace Russia

MOTHER
14. Maiden Name Kupra —
15. Birthplace Russia

16 (a) Informant Frieda Krauss
(b) Address 3800 Woodhaven Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-43 (month) (day) (year)

(c) Cemetery or crematory Wurlman Circle
Location Hebrew Mt. Carmel

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E. Balto. St

MAR 11 1944 (Date received by registrar) (b) Huntington Williams M.D. (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-44 19 , at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 1943, to March 1944 and that I last saw h alive on March 5 19 44.

Immediate cause of death
Cancer of the stomach metastasis to the liver

Duration 6 mo?

Due to

Due to

Other Conditions Hepatomegaly
Ascites
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Slanfax M.D.
M. D.

Address 5106 Park Heights Ave Date signed 3/13/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15058
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2711 N Baltimore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days 20 4
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 N Baltimore St
(If rural give location)
(e) Citizen of foreign country? — Yes or No
If yes, name country

3 (a) FULL NAME Harry Petersen

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-04-8201

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna McPetersen

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 28-1879

8. AGE: Years 65 | Months 11 | Days 12 | If less than one day: hr. min

9. Birthplace Denmark
(town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Steredore Penny Loader

FATHER
12. Name Hellmuth Petersen
13. Birthplace Denmark

MOTHER
14. Maiden Name —
15. Birthplace Denmark

16 (a) Informant Anna Mc Petersen
(b) Address 2711 N. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14-44 (month, day, year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director J. B. Whitehurst Son
(b) Address 150 N. Baltimore St

19 (a) Date received MAR 14 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944 at 11 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 1/18/44 19 to 3/11/ 1944, that I last saw him alive on 3/10/ 1944.

Immediate cause of death: Hypotensive cardio vascular disease. — Duration: ?

Due to

Due to

Other Conditions: Acute cholecystitis. 3 - 4 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury

23. Signature Harry Deiel M. D.
Address 1226 Hanover St. Date signed 3/13/ 1944.

PHYSICIAN
Underline the cause to which death should be charged statistically

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 D

G 15059
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2805 Alsa Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. yrs., mos., or days —
(e) Length of stay in Baltimore yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED:
a State Md b County
c City or town Baltimore
(If outside city or town limits, write (R.A.) and give town)
d Street No. 2805 Alsa Ave
(If rural give location)
e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME J. Henry Albrecht

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mame Albrecht
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Oct 26-1869

8. AGE: Years	Months	Days	If less than one day
74	4	15	hr. min

9. Birthplace (State or foreign country) Germany
(Town, county, and state)
10. Usual Occupation Precision Instrument Co
11. Industry or business

FATHER
12. Name Philipp A. Albrecht
13. Birthplace Germany

MOTHER
14. Maiden Name Eleonora Longenecker
15. Birthplace Md

16 (a) Informant Mrs Mame Albrecht
(b) Address 2805 Alsa Ave

17 (a) Buried (b) Date thereof Mar 14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director F. D. Wilhelm & Son
(b) Address 1301 Eutaw Place

19 (a) Date received by registrar MAR 14 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21- 1944, to 3-11- 1944, and that I last saw him alive on 3-9- 1944.

Immediate cause of death Carcinoma of Liver — Duration 6 wks

Due to Carcinoma of recto-sigmoid junction — ?

Due to

Other Conditions

Include pregnancy within 3 months of death.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fulton C. Pauq M. D
Address 217 Belair Rd Date signed 3-13-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

✓ G 15060

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1409 E. Fairmount Ave (If rural give residence)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 49 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS [illegible] 1 1944

Commissioner of Health

18 (a) Funeral director

(b) Address

MAR 1 1944 (b) Huntingtown Williams Md

(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 19 44, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on March 5 19 44

Immediate cause of death Cardiac insufficiency — Duration

Due to Hypertensive

Due to cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John R. Birmingham JHH

Address Date signed 3-5

0789

G 15061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 15061
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 S. Broadway (Rooms)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Long

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
—	214-22-7995	Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1886

8. AGE: Years	Months	Days	If less than one day hr.	min.
58	-	9		

9. Birthplace Orangeburg, S.C.
(Town, county, and state)
10. Usual Occupation Shipper
11. Industry or business Deatifield Shipyards

FATHER
12. Name Elijah Long
13. Birthplace N.C.

MOTHER
14. Maiden Name Susannah McAmen
15. Birthplace S.C.

16 (a) Informant George Smith
(b) Address Kirby Mountain, S.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo F. Cook
(b) Address 1701-03 N. Patterson Park Ave.

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-1944, at 7 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weinstein M.D.
Medical Examiner.
Date signed 3-8-44

G 15062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15062
Registered No.

correct age is especially important. Foreigners: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 North Broadway
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Huntingtown
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME William A Fowler

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	(Married) Widowed

6 (b) Name of husband or wife ~~Mrs~~ Elizabeth Fowler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 11, 1865

8. AGE: Years	Months	Days	If less than one day
78	3	3	hr min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business —

FATHER
12. Name Alexander Fowler
13. Birthplace Ohio

MOTHER
14. Maiden Name Ann Buckler
15. Birthplace Ohio

16 (a) Informant William Fowler
(b) Address 1612 Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory All Saints
Location Calvert Co. Md.

18 (a) Funeral director Wm H. Hutchins
(b) Address Owings, Calvert Co. Md.

19 (a) (Date rec'd by registrar) (b) Huntingtown Williams, M.D. Registrar

MAR 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1944, at 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 3 1944, to Mar. 14 1944, and that I last saw him alive on Mar. 13 1944.

Immediate cause of death Mesenteric Thrombosis

	Duration
Due to Embolism?	
Due to Arteriosclerotic Heart Disease	
Other Conditions Auricular Fibrillation, Arteriosclerotic Gangrene Left Foot. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Stevens Hatch M. D.
Address Church Home Hosp. Date signed 3-14-44

G 15063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15063 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 S/F Baker
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S/F Baker St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dovey Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John W Dorsey
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan ? 1866

8. AGE: Years 77 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ruth Rotmans
(b) Address 5 S/F Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geary F. Kelly
(b) Address 1303 Edmondson Ave

19 (a) (Registered by registrar) (b) Huntington Williams, M.D. Registrar

MAR 14 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 19XX at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 19XX to Mar 12 19XX and that I last saw h alive on Feb 20 19XX.

Immediate cause of death Cardio Vascular Renal Disease — Duration 3

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E William Frey, M.D.
Address 198 Fulton Ave Date signed 3/14/44

Correct age is especially important. Please write the cause of death clearly and legibly.

G 15064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15064 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3323 Beech Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3323 Beech Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Julian Lucabaugh

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John P. Lucabaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12-1857

8. AGE: Years 89 | Months 4 | Days 29 | If less than one day: hr. min.

9. Birthplace York Co. Pennsylvania (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

MOTHER / FATHER
12. Name Jonathan Rohrbaugh
13. Birthplace Pennsylvania
14. Maiden Name Sara Bortner
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Joseph P. Shock
(b) Address 3323 Beech Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Pattapsco [illegible]

19 (a) MAR 14 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11- 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1944, to MARCH 11 1944, and that I last saw h[illegible] alive on 3-11- 1944.

Immediate cause of death: Myocardial insufficiency — Duration 2 days
Due to Arteriosclerosis — 15 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Aubrey J. Davis, M. D.
Address 800 N 33rd Date signed 4-13-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

15065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

G 15065
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Paca Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Garland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1939

8. AGE: Years	Months	Days	If less than one day
4	7		hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name James Garland
13. Birthplace S. C.

MOTHER
14. Maiden Name Viola Wheeler
15. Birthplace S. C.

16 (a) Informant Ben Garland
(b) Address 1935 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto City, Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

(c) (Date rec'd by registrar) MAR 1 1944 (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20

20. DATE OF DEATH March 12 1944 at 10 P. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy / Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Burns, 2nd and 3rd degree face & trunk

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/12/44 at 10:15 P. M.
(b) Where did injury occur? 521 N. Paca Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury oil burner exploded

23. Signature H. Z. Wollenweber M.D.
Medical Examiner.
Date signed 3-13-44

15066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G 15066
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town STEMMERS RUN (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OSCAR Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	BLACK	Divorced

6 (b) Name of husband or wife Married

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75 76			hr. min.

9. Birthplace Crisfield Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 15 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Cabary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAR 14 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1944, at 7.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Gastro - Intestinal Hemorrhage — Duration

Due to carcinoma of stomach — 1 year

Due to

Other Conditions Arteriosclerotic H.D. Dry gangrene 1 & 4 toes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Gerson M. D.
Address J. Hopkins Date signed 3-1-44

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

449942 G 15067 BALTIMORE CITY HEALTH DEPARTMENT ✓ G 15067

CERTIFICATE OF DEATH 157E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3435 Patan ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marvin Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/8/43

8. AGE: Years	Months	Days	If less than one day hr.	min.
	4			

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace
14. Maiden Name Viola Thomas
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Charles R Law
(b) Address 802 Madison Ave.

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 14 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23 1944, to Mar. 10 1944, and that I last saw h[illegible] alive on Mar. 10 1944.

Immediate cause of death Cardiac failure — Duration 6 hrs

Due to pneumonia — 12 days

Due to

Other Conditions Congenital heart disease — Atelectasis?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp. Date signed 3-11-44

Correct age is especially important. Physicians: please write the cause or death clearly and legibly.

15068 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓ Registered No. G 15068

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 Forman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Forman St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Pratt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife John Pratt
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883 ?

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Kinsale Va.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Dean
13. Birthplace Va

MOTHER
14. Maiden Name Amanda ?
15. Birthplace Va.

16 (a) Informant Joseph Dean
(b) Address 1811 Forman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balt. Co. Md.

18 (a) Funeral director Chas H Alexander
(b) Address 927 N. Mount St

MAR 14 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13 19 44, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 19 43, to Mar 13 19 44, and that I last saw her alive on Mar 10 19 44.

Immediate cause of death	Duration
Cardio Vascular Disease	1 yr.
Due to Hemiplegia	1 yr.
Due to Cerebral Hemorrhage	3 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Frey
Address 1923 Fulton Ave Date signed 3/16/44

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

(#49785) BALTIMORE CITY HEALTH DEPARTMENT G 15069

CERTIFICATE OF DEATH

46F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert Co.
(c) City or town Chesapeake Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	black	married

6 (b) Name of husband or wife Henry Chase
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Patrick Gaut
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Morsell
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 16 (day) 44 (year)
(c) Cemetery or crematory Patapsco
Location Baltimore Co

18 (a) Funeral director P. C. Sprucebanks
(b) Address Prince Frederick Md.

19 (a) (Date rec'd by registrar) MAR 14 1944 (b) Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1944 to Mar. 12 1944 and that I last saw her alive on Mar. 12 1944.

Immediate cause of death Carcinoma of Liver — Duration 3 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-10-44

Major findings of operation: Carcinoma of liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature George Brunch
Johns Hopkins Hosp Date signed 3-13-44

G 15070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 15070 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2560 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 5
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs. 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2560 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph James Hinchen

3 (b) If veteran, name war Spanish Am. War

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	widowed

6 (b) Name of husband or wife Mary Hagan Hinchen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1861

8. AGE: Years	Months	Days	If less than one day hr.	min.
83	6 5	1		

9. Birthplace Baltimore City Md. (Town, county, and state)
10. Usual Occupation retired U. S. Army
11. Industry or business

MOTHER / FATHER
12. Name Frederick Hinchen
13. Birthplace U.S.A.
14. Maiden Name Elizabeth James
15. Birthplace England

16 (a) Informant Mrs. Etta Massey
(b) Address 2560 Harlem Ave. Balto, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 16 44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director Jos. E. Myers, Jr.
(b) Address Catonsville, Md.

19 (a) MAR 14 1944 (b) Theating for Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1944 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1944 to 3-13 1944 and that I last saw him alive on 3-13 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 3321 Frederick Ave Date signed 3-13-44

G 15071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15071 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 FOURTH ST. BROOKLYN
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 FOURTH ST. BROOKLYN (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH F. BARTH SR.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212 07 3168

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ROSA BARTH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 14 1883

8. AGE: Years	Months	Days	If less than one day
61	1	25 27	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation BOX MAKER
11. Industry or business

FATHER
12. Name JACOB BARTH
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO. MD.

16 (a) Informant ROSA BARTH (WIFE)
(b) Address 3809 FOURTH ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 15/44 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location ANNAPOLIS ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MAR 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 11 19 44 at 1/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1944 to Mar 11 1944 and that I last saw him alive on Mar 11 1944

Immediate cause of death	Duration
Coronary occlusion	
Due to hypertension	
Due to C. disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Winter. MD
Address 302 Patapsco M. D. Date signed 3/12/44

G 15072

AB-86716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 15072 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S. Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Appel

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 15 1887

8. AGE: Years 56 | Months 6 | Days 29 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Huxter (Huckster) - Self

11. Industry or business

FATHER
12. Name Charles Appel (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Miller (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 15/44 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Lillyard Zeiler INC.
(b) Address 403 S. WOLFE ST. Williamsport, Md.

19 (a) (Date rec'd by Registrar) MAR 14 1944 Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 12 - 1944 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 1 - 1944 to 3 - 12 - 1944, and that I last saw him alive on 3 - 11 - 1944

Immediate cause of death: pulmonary Tbc.

Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: pulmonary Tbc.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Ehrlich M. D.
Address 4940 Eastern Ave Date signed 3-13-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15073 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Penna ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State M. D. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lona Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-1909

8. AGE: Years 35 | Months - | Days 3 | If less than one day hr. min.

9. Birthplace Sumpter S. C.
(town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Aaron Johnson
13. Birthplace S. C.

MOTHER 14. Maiden Name Lona Green
15. Birthplace S. C.

16 (a) Informant Mabell Frierson
(b) Address 151 W. Cross St

17 (a) Shipped (b) Date thereof 3-15-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sumpter Cem
Location Sumpter South-Carolina

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

MAR 14 1944

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH mar 13 1944 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1943 to 3/13 1944, and that I last saw h alive on 3/13 1944.

Immediate cause of death Aortic Aneurysm — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Saunders

Address Lee Date signed 3/14/44 M. D.

G 15074 Transcript

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G 15074 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 E. 20th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 E 20th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Frank A. Gallagher

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
46	—	—	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Auto Mech
11. Industry or business

FATHER 12. Name John J. Gallagher
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Agnes Gallagher
15. Birthplace Pennsylvania

16 (a) Informant Mrs Frank Gallagher
(b) Address 403 E 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Mayne Niedefuer
(b) Address 501 E. 22nd St

19 (a) MAR 14 1944 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1944 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6-44 to 3-12-44, and that I last saw him alive on 3-12-1944

Immediate cause of death	Duration
Due to Bronchopneumonia	1 week
Due to Cardiac Dilatation	several months
Other Conditions Valvular disease	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harlan C. Blake M. D.
Address Med-Dent Bldg Date signed

M. D. B. 1269-0

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 15075

CERTIFICATE OF DEATH

159 G 15075

1. PLACE OF DEATH

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1101 Clank Court St., 11 Ward)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Baby Boy Williams

(a) Residence: No. 1101 Clank Ct St., Ward 25
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day, year) 3/12/44

7. AGE	Years	Months	Days	If LESS than 1 day 6 hrs. or 20 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Curtis Bay Maryland

FATHER

13. NAME Henley Williams

14. BIRTHPLACE (city or town) (State or country) Hancock County Tennessee

MOTHER

15. MAIDEN NAME Sallie Tipton

16. BIRTHPLACE (city or town) (State or country) Green County Tennessee

17. INFORMANT Hetty Wellesink
(Address) 1101 Clank Ct Curtis Bay Md

18. BURIAL, CREMATION, OR REMOVAL Oak Ridge Cemetery
Place Greenville, Tenn. Date Mar 15 1944

19. UNDERTAKER Chas. W. Tuchenhagen
(Address) 637 Wash Blvd.

20. FILED MAR 14 1944 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 13, 1944

22. I HEREBY CERTIFY, That I attended deceased from March 13, 1944 to March 13, 1944

I last saw h/ alive on March 13, 1944. Death is said to have occurred on the date stated above, at 3:30 P.m.

The principal cause of death and related causes of importance were as follows:

	Interval between onset and death
Atelectasis (Fetal)	3/13/44
Prematurity	3/13/44

Other contributory causes of importance:

Name of operation. Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of Injury ..., 19...

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Paul Lukon M. D.

(Address) 320 Patapsco Ave

G 15076

JL- 86929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15076 9

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 W. Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Rose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1942

8. AGE: Years	Months	Days	If less than one day
1	4	4	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Marcellus Rose
13. Birthplace S. C.

MOTHER
14. Maiden Name Almira Gentery
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Doyle
(b) Address 4011 Mount Street

MAR 14 1944 Huntington Williams, M.D. Registrar

NR-180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13 1944, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1944, to 3-13 1944, and that I last saw her alive on 3-13 1944.

Immediate cause of death: Myocardial insufficiency — Duration: 3 days

Due to pneumonia (broncho-) — 1 wk

Due to pertussis — 1 month

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seyman, M. D.

Address BCH Date signed 3/14

Subject age is especially important. Physician, please write the causes of death clearly and legibly.

G 15077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 15077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 S.Gilmore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

19

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 S.Gilmore St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Marchleck

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Julius
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.31,1869

8. AGE: Years	Months	Days	If less than one day
74	1	11 14	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Finch
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name not known
15. Birthplace " "

16 (a) Informant Julius Marchleck
(b) Address 301 S.Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway.

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

MAR 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 2nd 1944. to March 12 1944 and that I last saw him alive March 12 1944

Immediate cause of death	Duration
(a) Cerebral Embolism of Hypertens Cardiac Disease	
Due to (b) Nephritis Chronic	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Koldewey M. D.
Address 1715 N Front Date signed 3/14/44

Theodore KOLDEWEY

Correct age is especially important when deceased is under one year, one month or one day. Also cause of death clearly and legibly.

G 15078

G 15078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MATILDA ALLEN Matilda (Hutchinson) Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Alonzo Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1910

8. AGE: Years	Months	Days	If less than one day
33 ~~24~~	4	23	24 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George T. Granruth
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary A. Berenger
15. Birthplace Baltimore Md.

16 (a) Informant John Granruth
(b) Address 2317 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) MAR 14 1944 (Received by registrar) (b) Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1944 (3 A M) to 3-13 1944 (6 A M).
and that I last saw h.er alive on 3-13 1944 (6 A M).

Immediate cause of death: miliary tuberculosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: miliary T B

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. S. Amrich M. D.
Address Sinai Hosp. Date signed 3-13-44

correct age is especially important. If unknown, give approximate age. Write the causes of death clearly and legibly.

G 15079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 15079 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 W. Hamburg St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 W. Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank E. Jones

3 (b) If veteran, name war no

3 (c) Social Security Account No. 218-12-2944

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Gertrude M. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14. 1869

8. AGE: Years 75 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace London, England (Town, county, and state)

10. Usual Occupation Retired - Baker

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Edgar G. Jones
(b) Address 5111 Ardmore Way.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 16. 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mr. Mrs. John F. Tenfelsdon
(b) Address 801 W. Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 14 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13 1944, at 3:05 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from March 7 19 44 to March 13 19 44 and that I last saw h alive on 3-13 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 3 Days

Due to Hypertension & Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 510 Belair R. Date signed 3-17 1944

correct age is especially important. Physicians please write the causes of death clearly and legibly.

G 15080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G 15080 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4405 Maine Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 & 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4405 Maine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles M. Loewer

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lena A. Loewer
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 26. 1870

8. AGE: Years 73 | Months 3 | Days 15 | If less than one day: 7 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired - Accountant
11. Industry or business B. O. R. R.

FATHER
12. Name Conrad Loewer
13. Birthplace Germany.

MOTHER
14. Maiden Name Eliza Haas
15. Birthplace Germany.

16 (a) Informant Lena A. Loewer
(b) Address 4405 Maine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 16 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 801 W. Lafayette St.

19 (a) MAR 14 1944 (Date rec'd by registrar) (b) Hunter & Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13 1944. 4-a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943. to March 13 1944.
and that I last saw h /his alive on March 13 1944.

Immediate cause of death: Angina Pectoris — Duration
Due to: Coronary Artery Disease
Due to: Generalized Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place) L. J. VOLENICIC
(e) Means of injury

23. Signature [signature]
Address 4710 Liberty Hts Date signed 3/13/44 M.D.

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G 15081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15081 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4332 Glenmore Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 4332 Glenmore Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael B. Command

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 214-14-9186

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margerite

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.) July 3 1875

8. AGE: Years 68 | Months 8 | Days 9 | If less than one day: hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER — 12. Name: John Command

13. Birthplace: Ireland

MOTHER — 14. Maiden Name: Catherine Brady

15. Birthplace: Ireland

16 (a) Informant: Carlton Command

(b) Address: 4332 Glenmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/44 (month) (day) (year)

(c) Cemetery or crematory: Moreland Memorial Park

Location: Taylor Ave.

18 (a) Funeral director: W. E. Dyer & Sons

(b) Address: Loudon & Ann Sts.

MAR 14 1944 (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1938, to March 12 1944, and that I last saw him alive on 3/11 1944.

Immediate cause of death: Ch. Myocarditis

Duration: 6 years

Due to: Cardiac asthma.

Due to: Arterio-sclerosis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J S Harding

Address 810 Belair Rd Date signed 3/13/44

D.O.A.
N.L.N. Dis. 5082

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 35

G 1.5082
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Bailey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	black	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1943

8. AGE: Years	Months	Days	If less than one day
1	15	18	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation child
11. Industry or business

MOTHER / FATHER
12. Name Edward Bailey Taylor
13. Birthplace
14. Maiden Name Hazel Bailey
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 800 Broadway

MAR 14 1944 (Date received by registrar) Hunting for William Tippett (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944 at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12 1944 to 19..., and that I last saw h[illegible] alive on Mar. 19...

Immediate cause of death Resp. failure — Duration

Due to pneumonia

Due to

Other Conditions measles

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp Date signed 3-15-44

G 15083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G 15083 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N. Pine Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha Ballard Johnson Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. ~~Married~~ Widowed

6 (b) Name of husband or wife George Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Dec~~ Mar 4 1888 Ret

8. AGE: Years 56 Months 11 Days 9 If less than one day hr. min

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Charles Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Jennie Hall
15. Birthplace Md

16 (a) Informant Clarence Johnson
(b) Address 902 Shald Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brandt Place

19 (a) 3-14-1944 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1944 at 6 A.M.

21. I certify that I took charge of the remains described above, held an Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Burns, 2nd and 3rd degree body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-12-44 at 10 A.M.
(b) Where did injury occur? 914 N. Pine Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Clothing caught fire while standing over coal stove.

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 3-13-44

Registrar

VS 151

Physicians: please write the causes of death clearly and legibly. Age is especially important.

G 15084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G 15084

Registered No. .....

Type or print in ink. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 W. Lanvale St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Perry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 6 mo | Days | If less than one day hr min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name DONALD PERRY

13. Birthplace MD

MOTHER 14. Maiden Name ADLEA PERRY

15. Birthplace MD.

16 (a) Informant DONALD PERRY

(b) Address 1012 W. LANVALE ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 15th/4 (month) (day) (year)

(c) Cemetery or crematory mt Zion

Location mt Wmana

18 (a) Funeral director Edwin O Wilson

(b) Address 1600 Brantley Ave

19 (a) ..... (b) ..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1944, at 12 Noon M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions Hydrocephalus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester J. Jablinski M.D.
Medical Examiner
Date signed 3/13/44

VS 151

G 15085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15085 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 E. Lombard. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melrose Eastern

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Elaine Nelson
(b) Address 510 S. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1944, at 9-7 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to a true death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McKelvey M.D. Medical Examiner
Date signed 3/12/44

15086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15086
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Asquith St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Asquith St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry August Scheper

3 (b) If veteran, name war ------

3 (c) Social Security Account No. none

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Laura V. Scheper--

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1864

8. AGE: Years 79 | Months 7 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Frederick Scheper
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Hackstedt
15. Birthplace Germany

16 (a) Informant Mrs. Laura V. Scheper
(b) Address 1119 Aisquith street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Chas. J. Eugene Doll Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) MAR 15 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1944, at 9.00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Eugene B. McNally M.D. Medical Examiner.
Date signed 3/14/44

VS 151

Notice: Age is especially important. Physicians: please write the causes of death clearly and legibly.

GF 15087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No. G 15087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 S. Broadway St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 S. Broadway St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Polucki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 78 Months Days If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name P.

FATHER 13. Birthplace Lith

MOTHER 14. Maiden Name P

MOTHER 15. Birthplace Lith

16 (a) Informant Helen Polucki

(b) Address 218 S. Broadway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 16 44 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cem

Location

18 (a) Funeral director Joseph Kasmykowski

(b) Address 622 Washington Blvd

MAR 15 1944 (Date received by registrar) Huntington Williams Sig. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1944 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943 to 3-12 1944 and that I last saw h[illegible] alive on 3-12 1944

Immediate cause of death: Cardiac Failure — Duration

Due to: Heart Block

Due to: cardiac Insuff Art Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Cohen M. D.

Address Marlborough Date signed

VS 180

G 18088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. G 15088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Mongolf Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph VOCELis (Vocelis)
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 212-14-8753

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1868
8. AGE: Years 76 | Months | Days | If less than one day hr. min.
9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Dishes Washer
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Mary Vocelis
(b) Address 822 Mongolf Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 16 '44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beloit Rd
18 (a) Funeral director Joseph Cognevich
(b) Address 60 W Washington Blvd
19 (a) MAR 15 1944 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944, at 1 40 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull
Multiple fractures of ribs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 12 1944 21 1 15 1 AM.
(b) Where did injury occur? In front of 704 Carroll St
(c) Did injury occur at home, on farm, industrial place, in public place? street While at work? No
(d) Means of injury pedest. struck by auto.
23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 16 1944

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

117a

Registered No. G 15089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1638 Kingsway Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto. - Northwood (If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 Kingsway Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas A. Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Leah M. Cunningham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 20th 1865

8. AGE: Years	Months	Days	If less than one day
78	11	22	hr. min.

9. Birthplace Newark N.J. (Town, county, and state)
10. Usual Occupation Retired Stage Manager
11. Industry or business Lyric Theatre

FATHER
12. Name Lawrence Cunningham
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Burns
15. Birthplace Scotland

16 (a) Informant George Cunningham
(b) Address 1638 Kingsway Rd. Northwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date received by local registrar) (b) Registrar

MAR 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12th 1944, at 1:45 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944, to March 11 1944, and that I last saw h alive on March 8 1944.

Immediate cause of death: Vascular obstruction (thrombosis) of the superior mesent. artery. — Duration 12 hours

Due to: Arteriosclerosis. — Duration many years

Due to:

Other Conditions: Gastric physical-cer (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred F. Liedemann M. D.
Address 3 E. Preston St. Date signed March 14 1944

G 15090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 15090 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 Briscoe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Briscoe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Earnest Niemann

3 (b) If veteran, name war –

3 (c) Social Security Account No. 216-03-5087

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Niemann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1893

8. AGE: Years	Months	Days	If less than one day
51	1	17	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business

FATHER
12. Name August Niemann
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Lynn
15. Birthplace Germany

16 (a) Informant Anna M. Niemann
(b) Address 1027 Briscoe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Annapolis Rd. Balto. Md.

18 (a) Funeral director Leonard L. Covington
(b) Address 2121 E. 25th St.

19 (a) MAR 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 12, 1944 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10/ 1944 to 3/12 1944 and that I last saw him alive on 3/11/ 1944.

Immediate cause of death: Broncho-pneumonia — Duration: 2 mos.

Due to

Due to

Other Conditions Acute myocarditis ~~AMS-~~ ~~WOODS~~

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel

Address 1226 Hanover St. Date signed 3/15/1944.

15091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D Town

G 15091 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 E 25th St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 E 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Stewart

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles A. Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1862

8. AGE: Years 81 | Months 10 | Days — | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business —

FATHER 12. Name William Riach
13. Birthplace Scotland

MOTHER 14. Maiden Name Margaret Troy
15. Birthplace Virginia

16 (a) Informant Eliza Stewart
(b) Address 213 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Md

18 (a) Funeral director Dunnard D'Garnton
(b) Address 21 W. 25th St

19 (a) MAR 15 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1944, at 6 10 P M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Thrombosis

Due to

Other Conditions Arteriosclerotic C.V. disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Clinton J. Imbrie M.D. Medical Examiner.
Date signed 3/17/44

VS 151

G 15092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15092 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 947 W Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 947 W Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Keyser

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1869

8. AGE: Years 74 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Keyser
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Louisa Hoffman
15. Birthplace Baltimore Md

16 (a) Informant Charles H Keyser
(b) Address 3205 Woodbourne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore Md

18 (a) Funeral director Wilson Conway Dye
(b) Address 1517 E Fayette St

MAR 15 1944 (Date rec'd by Registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1944 to March 12 1944 and that I last saw h alive on March 9 1944

Immediate cause of death: Bronchopneumonia — Duration 2 wks

Due to

Due to

Other Conditions Arteriosclerosis Cardiac Renal Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin Fleming M.D.
M. D.

Address 1984 W. Balto St. Date signed 3-13-44

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

45093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 45093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 E. Lorraine Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 E. Lorraine ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Miskimon

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband ~~or wife~~ Harry M. Miskimon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10th 1856

8. AGE: Years 87 | Months 7 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER
12. Name Joseph Lewis
13. Birthplace Md.

MOTHER
14. Maiden Name Frances Gaugh
15. Birthplace Md.

16 (a) Informant Josephine MisKimon
(b) Address 421 E. Lorraine Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Bolz Inc
(b) Address 1217 St. Paul St

19 (a) MAR 15 1944 (Date rec'd by registrar) (b) Hunter-Lee-Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14- 1944, at 11:30 AM

21. I certify that I took charge of the remains described above, held an ~~inspection or~~ Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~her~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 3-14-44

15094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 15094
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3511 Old Frederick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 Old Frederick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine E. Duffy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Michael J. Duffy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1873

8. AGE: Years 70 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Luke Carr
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget (Mulrooney)
15. Birthplace Ireland

16 (a) Informant Luke Duffy
(b) Address 3511 Old Frederick Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1937, to March 14 1944, and that I last saw her alive on March 14 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days
Due to: Cardio-Vascular Renal & Hypertension — 3½ Years
Due to:
Other Conditions: Diabetes Mellitus — 7 Years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson, M.D.
Address 3432 Druid Hill Ave. Date signed 3/15/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 15095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G 15095 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5004 Beaufort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5004 Beaufort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margarete L. Switzer,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6. 1868

8. AGE: Years 75 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Switzer,
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Hartzell,
15. Birthplace Baltimore Md.

16 (a) Informant Leonard G. Switzer,
(b) Address 5004 Beaufort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15. 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by registrar) MAR 15 1944 (b) Registrar

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 13 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 19 44 to March 13 19 44, and that I last saw h alive on March 13 19 44

Immediate cause of death: Cerebral Haemorrhage — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Lowman M. D.
Address 5013 Park Heights Ave Date signed 3-14-44

G 15096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registered No. G 15096

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: East Balto Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Perry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Timothy Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44 43			hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Thomas Young
(b) Address 124 Perry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 17-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md

18 (a) Funeral director James A Otaye
(b) Address 1142 West Balto St

19 (a) MAR 15 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11-1944, at 4:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Acute Ulcerative Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed 3-11-44

G 15097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G 15097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Penna. Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Moore

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virginia C. Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1899

8. AGE: Years 44 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Jamesville, Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Irwin Moore
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Kendall
15. Birthplace Va.

16 (a) Informant Virginia C. Moore
(b) Address 1306 Pennsylvania Ave.

17 (a) Burial (b) Date thereof March 15, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1618 Druid Hill Ave

19 (a) MAR 13 1944 (b) Hunting for Williams
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10- 19 44, at 10 55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-10-44 at 10 45 P M.
(b) Where did injury occur? 1320 Penna.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Blunt instrument

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-11-44

G 15098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 15098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Tate Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 24 | Months | Days | If less than one day: hr. min.

9. Birthplace Cleveland Georgia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Lottie Moore
15. Birthplace Georgia

16 (a) Informant Virginia C. Moore
(b) Address 1320 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Gainesville, Ga.

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) MAR 15 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1944, at 2 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to Blunt force

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-10-44 at 10:45 P. M.
(b) Where did injury occur? 1320 Pennsylvania Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Struck on head with

23. Signature H. L. Williams Deputy Medical Examiner M.D.
Date signed 3-13-44

VS 151

G 15099

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 15099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Penna. Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Thomas B. Tate

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 29, 1911

8. AGE: Years	Months	Days	If less than one day
32	7	11	hr. min.

9. Birthplace Jamesville Ga. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Boaz Tate
13. Birthplace Ga.

MOTHER
14. Maiden Name Mary Kentrall
15. Birthplace Ga.

16 (a) Informant Virginia C. Moore
(b) Address 13 E. Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Gainesville, Ga.

18 (a) Funeral director Mr. Geo. A. Holland
(b) Address 1631 Druid Hill Ave

19 (a) MAR 15 1944 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10-44, at 10.45 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Compound Comminuted fracture of skull, intracranial hemorrhage & laceration brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-10-44 at 10.45 P.M.
(b) Where did injury occur? 1320 Penna. Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Blunt instrument

23. Signature Howard J. Mallais M.D. Medical Examiner.
Date signed 3-11-44

VS 181

G 15100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 15100 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp., Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 16 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1253 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? Na (Yes or No)
If yes, name country

3 (a) FULL NAME Walter G. Medinger (Walter George Medinger)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1885

8. AGE: Years 58 | Months 4 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Credit Investigator

11. Industry or business

FATHER 12. Name William H. Medinger

FATHER 13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Ida Jane Kahl

MOTHER 15. Birthplace Balto., Md.

16 (a) Informant Mrs. Eva M. Medinger

(b) Address 1253 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date received by registrar) MAR 15 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1944 at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10:30 AM 3/14 1944 to 10:50 AM 3/14 1944, and that I last saw him alive on 3/14 1944.

	Duration
Immediate cause of death: Cardio-respiratory failure	
Due to: Cerebro-vascular hemorrhage	2 hrs.
Due to: Hypertensive C-V Disease	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred W. Dann M. D.

Address Sinai Hosp. Date signed 3/14/44

Hunting

G 15101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15101 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1800 W. Mosher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

16-44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 W. Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BERNARD MILLS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Emma Mills
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1859

8. AGE: Years	Months	Days	If less than one day
84	9	29	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business Self - retired

FATHER
12. Name Bernard Mills
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Gore
15. Birthplace Md.

16 (a) Informant Mrs. Mary E. Mills
(b) Address 1800 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 15 1944 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1944, at 7:42 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 9 1944 to Mar 13 1944 and that I last saw h alive on Mar 13 1944

Immediate cause of death	Duration
Coronary Thrombosis	3/9/44
Due to	
Due to Chr. Myocarditis	1840
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown M. D.
Address 1663W-Mont Dr Date signed 3/14/44

Paul Brown

G 15102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

✓ G 15102 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Fleet Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anthony J. Kiel

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-22-5862

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH-8-1929

8. AGE: Years	Months	Days	If less than one day
15 16	-	6	hr min.

9. Birthplace BALTIMORE Md. (Town, county, and state)

10. Usual Occupation CHAUFFEUR

11. Industry or business U.S. MAIL

FATHER 12. Name William Kiel

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Helen Gore

15. Birthplace Baltimore, Md.

16 (a) Informant Helen SZCZESNIAK MOTHER

(b) Address 2313 Fleet street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location BALTIMORE COUNTY Md

18 (a) Funeral director George A. Weber

(b) Address 705 S. Ann St.

19 (a) MAR 15 1944 (Date rec'd by Registrar) (b) Huntingtown Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1944, at 12 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10:20 AM 3-14-44 M.

(b) Where did injury occur? 50 feet of Collington Ave. Fleet St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes

(d) Means of injury Truck struck curb and overturned

23. Signature Robert L. Gutstein M.D. Medical Examiner.

Date signed March 14 1944.

VS 151

Physicians: please write the causes of death clearly and legibly. The accompanying supplement should be carefully filled out and signed.

15103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15103 Registered No.

PLEASE-WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess at correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1236 N Eden St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Keene

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Widowed

6 (b) Name of husband or wife Ellen Jr. Keene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 1837

8. AGE: Years	Months	Days	If less than one day
92	2	13	hr. min.

9. Birthplace Dorchester Co Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Charles Keene
13. Birthplace Dorchester Co, Md

MOTHER 14. Maiden Name Lucinda
15. Birthplace Dorchester Co Md

16 (a) Informant Mamie Wilkins
(b) Address 1236 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/44 (Month) (day) (year)
(c) Cemetery or crematory Oldfield
Location Dorchester Co Md

18 (a) Funeral director Robert E. Williams
(b) Address 515 McElderry St

19 (a) MAR 15 1944 (Date rec'd by registrar) Huntingtown Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944 at 7 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to March 11 1944 and that I last saw h alive on March 10 1944

Immediate cause of death

Due to Chronic Myocarditis and Arteriosclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Jan 1944

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. J. Allen M.D.
Address 124 Augusta St Date signed 3/14/44

G 15104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 15104 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State Md (b) County
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 136 Jackson Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Goldstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-15-91

8. AGE: Years	Months	Days	If less than one day
52	9	29	hr min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Samuel Goldstein
FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name ?
MOTHER 15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (Registrar)

MAR 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14 1944 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 14 19 44 to Mar 14 1944 and that I last saw him alive on Mar 14 19 44

Immediate cause of death: Coronary thrombosis — Duration

Due to: Arteriosclerotic heart disease

Other Conditions: detached retina
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R Birmingham M. D.
Address JHH Date signed 3-14

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15105 Registered No. 131a

G 15105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospt

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 312 N. Bdwy (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Annie Steni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
fem.	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Russia

13. Birthplace

MOTHER 14. Maiden Name Bella

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale Location Philad Rd & Hamilton Ave

18 (a) Funeral director Jack Levy Inc

(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form MAR 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1944, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1944 to 3/14 1944, and that I last saw her alive on 3/14 1944.

Immediate cause of death Cardiac failure — Duration

Due to Myocardial infarction

Due to Hypertensive, arterio-sclerotic h. dis

Other Conditions nephrosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Aekman M. D.

Address Sinai Hosp Date signed 3/14/44

G 15106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No. G 15106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Park Heights Ave

(c) Hospital or institution: Mt Sinai Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1703 N. Pulaski St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Morris FEINBERG

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER | FATHER

12. Name Not Known

13. Birthplace Russia

14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Harry Feinberg

(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3-15-44 (month) (day) (year)

(c) Cemetery or crematory Herring Run

Location Park Rd & Brooklyn Ave

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Baltimore

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15-44 19 , at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1944, to 3/14 1944, and that I last saw him alive on 3/14 1944.

Immediate cause of death Acute cerebral Hemorrhage — **Duration**

Due to Ch. arteriosclerosis

Due to Ch Uremia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. H. Hornstein M. D.

Address 733 Eutaw St Date signed 3/16/44

VS-180

G 15107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63c

G 15107 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 LEIGHTON AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Leighton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gertrude R. MANSTOFF

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Samuel.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57	0		hr. min.

9. Birthplace Poth (Town, county, and state)
10. Usual Occupation Nurse wife
11. Industry or business

FATHER
12. Name Lazer Silver
13. Birthplace Poth

MOTHER
14. Maiden Name Minda Chia -
15. Birthplace Poth

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-44 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem.
Location Wash. Blvd.

18 (a) Funeral director Jos Penn Inc
(b) Address 1439 E. Balto. St

19 (a) MAR 15 19 (Endorsed by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14-44 19 . at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 43 to 3-14 19 44
and that I last saw h alive on March 19 44.

Immediate cause of death
Acute Coronary occlusion
Coronary sclerosis
Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Duration Sudden yrs

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] MD
Address 704 Reservoir Date signed 3/15/44

G 15108

AB-85782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G 15108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Pitcher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6-1868

8. AGE: Years 75 Months 8 Days 6 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Poulson (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Jane (?)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 32 E N. Edmondson Av.

19 (a) Date received by Registrar MAR 15 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1944, at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1944, to 3-12 1944, and that I last saw h alive on 3-12 1944.

Immediate cause of death: ? Coronary Occlusion — Duration 6 hours

Due to Arteriosclerotic & hypertensive cardio vascular disease with failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattina M. D.

Address B.C.H. Date signed 3-13-44.

G 15109

JL- 82663

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12C

G 15109
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7- 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Watkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1924

8. AGE: Years	Months	Days	If less than one day
19	6	17	hr min

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name James Watkins
13. Birthplace Md.
14. Maiden Name Alverta Hall
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 11 - 1944 at 9.20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 29, 1944 to 3 - 11 - 1944, and that I last saw her alive on 3 - 10 - 1944.

Immediate cause of death: pulmonary Tbc — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: pulmonary Tbc.

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Ehrlich
Address 4940 Eastern Ave. Date signed 3-13-44 M. D.

VS 150

G 15110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G 15110 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S.Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 2/23/44
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Calhoun St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WASHINGTON BROWN

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Mar.
6 (b) Name of husband or wife: Della Kellum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1893

8. AGE: Years 50 | Months 2 | Days 14 | If less than one day: hr. 16 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Porter-3339 Cosdale Rd.
11. Industry or business

FATHER
12. Name William Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine
15. Birthplace Va.

16 (a) Informant records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial P.K. Location Baltimore Md

18 (a) Funeral director Charles S Cooper
(b) Address 512 N Carrollton Ave

19 (a) MAR 15 1944 (Date received by local registrar) (b) Huntingtown Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1944 at 10:37 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb.23, 1944 to Mar. 10, 1944. and that I last saw him alive on March 10, 1944

Immediate cause of death Hemorrhage from esophageal varices — Duration 2 days

Due to Cirrhosis of liver & Carcinoma of liver — 6 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/2/44-Exploratory lap.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles S Jones M. D.
Address Baltimore, Md. Date signed 3/10/44

Va-14326

G 15111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 15111 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Rutland Ave
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Rutland Ave (If rural give location)
(e) Citizen of foreign country? Yes or No) If yes, name country

3 (a) FULL NAME James Oliver Stuck

3 (b) If veteran, name war: World War No. 1.
3 (c) Social Security Account No. 216-09-4090

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Josephine M. Stuck
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug 30 1889

8. AGE: Years	Months	Days	If less than one day
54	6	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Machinist, at
11. Industry or business Wm. Hutchesons Sons

FATHER
12. Name Joseph Stuck
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Callahan
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Josephine M. Stuck
(b) Address 1815 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 17/44 (month) (day) (year)
(c) Cemetery or crematory Balto, Nat. Cemetery
Location 5501 Frederick Rd

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

MAR 15 1944 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1944 to 3/14 1944, and that I last saw h[illegible] alive on 3/13 1944

Immediate cause of death Coronary Thrombosis — Duration 15 Days

Due to

Due to

Other Conditions Degenerative

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen O'Delcamp M. D.
Address 5939 Fox Ellicott City Date signed 3/14/44

C 15112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 35

Registered No. C 15112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 McElderry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 McElderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) **FULL NAME** Bennie Richard Mc Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-43

8. AGE: Years 7 | Months 5 | Days 14 | If less than one day hr. min. 29

9. Birthplace Winston Salem N. C (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Isreal Mc Morris

13. Birthplace Newburn S C

14. Maiden Name Etta Mae Ross

15. Birthplace Ridgeroad S C

16 (a) Informant Isreal Mc Morris

(b) Address 1115 Mc Elderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co. Md

18 (a) Funeral director Byron Benjamin H. Wright

(b) Address 721 Pisquith St

19 (a) (Date received by local registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13- 1944. at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1944 to Mar. 13 1944. and that I last saw him alive on Mar. 10, 1944.

Immediate cause of death Broncho Pneumonia

Due to measles

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C R. Campbell M. D.

Address 718 Dolphin St. Date signed 3-15-44

G 15113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 186a G 15113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 448 W. 23rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1904

8. AGE: Years	Months	Days	If less than one day: hr.	min
39	9	20		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name John Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Nellie McGonigle
15. Birthplace Ireland

16 (a) Informant Nellie Miller
(b) Address 446 W 23rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 18 '44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Fireland, Md

18 (a) Funeral director Edward J. Corrigan
(b) Address 1416-17 Eutaw Pl

19 (a) (Date rec'd by registrar) APR 5 1944 Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1944 at 9:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural hemorrhage

Due to Fracture of skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/7

(a) Date of injury March 13 1944 9:30 P M.
(b) Where did injury occur? 26th St & Huntingdon Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Fall & shock

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 15 1944

(over)

C 15114

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 72a

C 15114 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. St Thomas Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY J. ADAMS Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1899

8. AGE: Years	Months	Days	If less than one day
44	7	18	hr. — min.

9. Birthplace Wash. D.C
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Harry J. Adams
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Annie Shirley
15. Birthplace Maryland

16 (a) Informant Annie Shirley
(b) Address St Thomas Lane Owings Mills

17 (a) Burial (b) Date thereof 5/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Charles
Location Pikesville Md

18 (a) Funeral director Frank H. Ingersoll
(b) Address Pikesville, Md.

19 (a) MAR 15 1944 Huntington Williams Md
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944, at 5 52 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Thrombocytic purpura

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. W. Allen Medical Examiner. M.D.
Date signed 3-13-44

G 15115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15115 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2902 Rueckert Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 Rueckert Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L Sheridan Hann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months — | Days — | If less than one day hr. min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name James Sheridan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Ruckle
15. Birthplace Baltimore

16 (a) Informant Sheridan Hann
(b) Address 2902 Rueckert Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-1944 (month) (day) (year)

(c) Cemetery or crematory [redacted]
Location London Park Cemetery

18 (a) Funeral director Mary Mc Wiedefeld
(b) Address 501 E. 32nd St

19 (a) (Date received by Local Registrar) (b) Registrar, M.D.
MAR 15 1944
Vs 280 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1944 at 9P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1943 to 3/13 1944, and that I last saw h alive on 3/13 1944

Immediate cause of death Chronic Infectious arthritis
Due to Chronic myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyacel Kelley M. D.

Address 5705 Harford Rd Date signed 3/15/44

450062 G 15116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32R

G 15116
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Parrish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Freeman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
	8			

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Owen Freeman
13. Birthplace Md.

MOTHER
14. Maiden Name Nicie Zeigler
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location West Port Balto St

18 (a) Funeral director George T.A. Gibson Jr
(b) Address 1735 Druid Hill Ave

19 (a) Huntington Williams, M.D. Registrar
(Date received by registrar) MAR 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1944, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1944 to Mar. 13 1944, and that I last saw him alive on Mar. 13 1944

Immediate cause of death respiratory failure

Due to Meningitis

Due to influenza

Other Conditions Sinus Thrombosis probable (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M. D.
Address Johns Hopkins Date signed 3-13-44

15117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 15117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:
U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 3/4/44

(e) Length of stay in Baltimore (yrs., mos., or days) Since 3/4/44

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Somerset

(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)

(d) Street No. - (If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WM. HENRY LONG

3 (b) If veteran, name war -

3 (c) Social Security Account No. 37-120-26

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Francis Purcell

6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1908

8. AGE: Years	Months	Days	If less than one day
35	3	13	hr. min

9. Birthplace Crisfield, Md.
(Town, county, and state)

10. Usual Occupation Deckhand

11. Industry or business Merchant Seaman

FATHER
12. Name John S. Long
13. Birthplace Crisfield, Md.

MOTHER
14. Maiden Name Minnie N. Evans
15. Birthplace Crisfield, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/44 (month, day, year)

(c) Cemetery or crematory Crisfield Cem.
Location Crisfield, Md.

18 (a) Funeral director Chas. Bradshaw
(b) Address Crisfield, Md.

MAR 15 1944 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH March 15, 1944, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4, 1944 to Mar. 15, 1944, and that I last saw him alive on Mar. 15, 1944.

Immediate cause of death	Duration
1. Diabetes Mellitus	Childhood
2. Subacute nephritis	Unk.
3. Pulmonary Tuberculosis	Unk.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: -

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. Schuerman M. D.

Address Baltimore, Md. Date signed 3/15/44

VS 180

MS-51469

Goscinian

G 15118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G 15118 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2539 Fait ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eileen Gosciniak

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1 [illegible]

8. AGE: Years	Months	Days	If less than one day: hr.	min.
	4			

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Gosciniah
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Wysnieski
15. Birthplace Baltimore Md

16 (a) Informant Frank Gosciniah
(b) Address 2539 Fait ave

17 (a) B (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year)
(c) Cemetery or crematory St Stanlaus
Location Dundalk ave

18 (a) Funeral director John J Duda
(b) Address 2929 Hudson St

MAR 15 1944

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1944, at 9:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 44, to March 13 19 44, and that I last saw her alive on 3/13/19 44.

Immediate cause of death Pulmonary edema — Duration

Due to Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Weimer M. D.
Address Date signed

Huntington Williamsport

15119
448972

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15119
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York City (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. 95th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Enrique L. Moreno
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1894

8. AGE: Years	Months	Days	If less than one day
49	6	27	hr. min.

9. Birthplace Puerto Rico (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business retired

MOTHER / FATHER
12. Name Rafael Moreno
13. Birthplace Spain
14. Maiden Name Rosario
15. Birthplace Spain

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Baltimore Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

MAR 15 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March. 12 1944, at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1944, to Mar. 12 1944, and that I last saw h~~im~~ alive on Mar. 12 1944.

Immediate cause of death Respiratory failure — Duration 6 hrs
Due to advanced pulmonary tuberculosis — 6 mos.
Due to Extreme cachexia : tuberculous enteritis — 6mos.
Other Conditions Sprue

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Spratt III M. D.
Address Johns Hopkins Hospital Date signed 3-12-44

G 15120

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15120

Registered No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lyden Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
d. Street No. 2017 Fleet St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Cybulski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1937

8. AGE: Years	Months	Days	If less than one day
9 Yrs	5	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Antone Cybulski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Krayer
15. Birthplace Balto. Md

16 (a) Informant R Kaye
(b) Address Lyndenhurst

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welby
(b) Address 408 S. Chester Street

19 (a) MAR 15 1944 (Date received by Registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1944 at 11 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11 1944 to 3-14 1944 and that I last saw her alive on 3/14 1944.

Immediate cause of death respiratory failure — Duration 6 days

Due to diphtheria

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rose Kaye

Address Lyndenhurst Date signed 3/16/44

(Over)

G 15121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 15121 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1914 N. Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ruth E. Warfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Thomas Warfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25th 1848

8. AGE: Years 95 | Months 7 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Carroll Co. Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Andrew Mercer
13. Birthplace Md.

MOTHER 14. Maiden Name Liza Shipley
15. Birthplace Md.

16 (a) Informant Florence Warfield
(b) Address 1914 N. Fulton Ave

17 (a) Removal (b) Date thereof 3/15/44
(~~Burial, cremation,~~ or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Rose Hill
Location Hagerstown Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) Date received by registrar MAR 15 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13th 1944 at 9 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Mar 13 1944, and that I last saw h[illegible] alive on Mar 12 1944.

Immediate cause of death: Senile General debility — Duration

Due to Cystitis - Chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Smith M. D.

Address 732 Druid Date signed 3/14/44

G 15122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15122
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Valley St
(c) Hospital or institution: Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Pich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frank
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Garmany
15. Birthplace Poland

16 (a) Informant Sisters of the Poor
(b) Address 1211 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 16. 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 947 Fremont Ave Huntingtown Williams, MD

19 (a) MAR 15 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION 5:30 p

20. DATE OF DEATH March 14 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1- 1944 to Mch 14- 1944, and that I last saw him alive on Mch 14- 1944.

Immediate cause of death	Duration
Bronchial Asthma	10 days
Due to Chronic myocarditis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 3/15/44

G 15123

G 15123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME Charles Gajkowski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day hr.	min.
80				

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Poland

MOTHER
14. Maiden Name Marie
15. Birthplace Poland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) 3-15-1944 (Date rec'd by registrar) (b) Huntington Williams Registrar M.D.

VS 150

MEDICAL CERTIFICATION 10.45 p

20. DATE OF DEATH March 14 1944, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 - 1944 to Mch 14 1944, and that I last saw h-- alive on Mch 14 1944.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 3/14/44

G 15124

YA-86792

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15124

Registered No. 518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Arie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1887

8. AGE: Years 56 | Months 3 | Days 18 | If less than one day: hr 19 min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Lebon Jones (d)
13. Birthplace Georgia

MOTHER
14. Maiden Name Madeline Bowtree (d)
15. Birthplace Georgia

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 3/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Hall
(b) Address 918 Druid Hill Ave.

19 MAR 15 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1944 to 3-14 1944, and that I last saw h alive on 3-14 1944.

Immediate cause of death

Duration

Uremia — 10 days

Due to Urinary Retention — 10 "

Due to Carcinoma of prostate — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-27-43

Major findings of operation: Ca of prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald B Abbott

Address Balto City Hosp Date signed 3-14-44
M. D.

G 15125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1216

G 15125 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 McKean Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 McKean Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Dina Eckardt.

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife George Eckardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1870

8. AGE: Years	Months	Days	If less than one day
73	8	19	0 hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wich
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Rosalie Eckardt
(b) Address 901 McKean Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-44 (month) (day) (year)
(c) Cemetery or crematory Elmwood Cemetery
Location Norfolk, Virginia

18 (a) Funeral director Leo. H. Eckardt
(b) Address 2101 Frederick Avenue

19 (a) Place of death (b) Registrar

MAR 16 1944

VS 13a

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1944 at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 4 1944 to Mar 14 1944, and that I last saw her alive on March 13, 1944.

Immediate cause of death Chr. Myocarditis — Duration

Due to

Due to

Other Conditions Chr nephritis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Shyman M.D.
Address 820 Mulberry St. Date signed 3/14/44

15126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15126
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 933 Gorsuch Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Audrey Ave - Brooklyn
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Kramme

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~Father~~ John A. Kramme
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19th 1859

8. AGE: Years 84 | Months 4 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Frank Hartman
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Margaret Short
(b) Address 935 Gorsuch Ave

17 (a) Burial (b) Date thereof 3/16/44
(Burial, ~~cremation~~, or removal) (month) (day) (year)
(c) ~~Cemetery or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Boyle Inc
(b) Address 217 St Paul St

19 MAR 16 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13th 1944, at 5 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from March 1944 to March 13 1944, and that I last saw ~~her~~ alive on March 13 1944

Immediate cause of death Myocardial Insufficiency

Due to

Due to

Other Conditions Arteriosclerosis, Hypertension, Myocarditis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Schwenck M. D.
Address 1317 S Clinton St Date signed 3/15/44

15127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G 15127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1149 Cleveland st
(c) Hospital or institution: 21 - 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 Cleveland st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Maria Bishop

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ George Bishop
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1875

8. AGE: Years	Months	Days	If less than one day
68	7	29	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name (Unknown) Goodman
13. Birthplace Ireland

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Robert W. Bishop
(b) Address 1149 Cleveland St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/18/44 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Western
Location Balto. Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 MAR 16 1944 (Date rec'd) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to March 15 1944, and that I last saw h~~im~~er alive on March 14 1944.

Immediate cause of death Carcinoma of Lung — | Duration 6 months

Due to | Duration

Due to | Duration

Other Conditions Hypertension Cardiovascular Disease | Duration 2 years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schofield, M. D.
Address 2301 Annapolis Rd. Date signed 3/15/44

VS 180

2301 Annapolis Rd.

15128 G 15128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B2 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 1825 Mc Culloh St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Mc Culloh St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Campbell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Henry A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1895

8. AGE: Years	Months	Days	If less than one day
47 48	11	20	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph A. Briscoe
13. Birthplace St Marys Co. Md.

MOTHER
14. Maiden Name Alice S. Johnson
15. Birthplace

16 (a) Informant Edward L. Campbell
(b) Address 1825 Mc Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1601 Druid Hill Ave.

MAR 16 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 1944 to March 12 1944, and that I last saw h[illegible] alive on March 5 1944.

Immediate cause of death	Duration
Cirrosis of Liver	3 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3/16/44

VS 180

G 15129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 15129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5619 Purdue Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5619 Purdue Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Goykow

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-05-8246

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva Goykow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 15 1878

8. AGE: Years 65 | Months 7 | Days 6 | If less than one day: 29 hr. min.

9. Birthplace: Hungary (Town, county, and state)

10. Usual Occupation: Blue Pants

11. Industry or business: Beth-Steel

FATHER
12. Name: George Goykow
13. Birthplace: Hungary

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Hungary

16 (a) Informant: Eva Goykow
(b) Address: 5619 Purdue Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-18-44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Pk
Location: Baltimore Md

18 (a) Funeral director: Leonard & Carrington
(b) Address: 21 W. 23rd St.

MAR 16 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 - 14 - 1944, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 - 10 - 1944 to 3 - 14 - 1944 and that I last saw alive on 3 - 12 - 1944.

Immediate cause of death	Duration
Coronary occlusion	Sudden
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm B. Tyler M. D.
Address 7802 Harford Rd Date signed 3-16-44

G 15130 ✓ G 15130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2237 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days) 37yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2237 E Baltimore St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Rebecca Palees

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Michael
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years: 80 | Months: | Days: | If less than one day: ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation .....
11. Industry or business None

FATHER
12. Name Joseph Caplan
13. Birthplace Russia

MOTHER
14. Maiden Name Annie ?
15. Birthplace Russia

16 (a) Informant Joseph Palees
(b) Address 114 S Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Adas Israel Cemetery
Location German Hill & North Point Rd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) ..... (Date received by Registrar) (b) ..... Registrar

MAR 16 1944 Hunting for Baltimore, Md.

MEDICAL CERTIFICATION

5.30

20. DATE OF DEATH March 16 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1944, to 3/16 1944, and that I last saw her alive on 3/15 1944.

Immediate cause of death: Arteriosclerotic Cardio-Vascular renal disease — Duration: 5

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
1944
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Joseph S. Bleeman M.D.
Address 606 S. Patterson Pk Ave Date signed 3/16/44

G 15131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15131 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Thomas Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME [illegible] Eben [illegible]

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	213-05-2713	male	white	married

6 (b) Name of husband or wife Jeannette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1890

8. AGE: Years	Months	Days	If less than one day
53	7	2	hr. min.

9. Birthplace Huntington, Pa. (Town, county, and state)
10. Usual Occupation Airoraft Worker
11. Industry or business Glenn L. Martin Co.

FATHER
12. Name John C. Lee
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Rodebaugh
15. Birthplace Pa.

16 (a) Informant Mr. John Lee
(b) Address 4004 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 16 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1944, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1944 to 3/14 1944, and that I last saw him alive on 3/14 1944.

Immediate cause of death [illegible] Duration 1 day

Due to Arteriosclerotic Cardio vascular disease ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner M. D.
Address 2401 W. North Ave Date signed 3/14/44

C 15132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B C 15132 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 230 S. Callington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 S. Callington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A. Dudzinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19 1919

8. AGE: Years 24 | Months 4 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Hoffman Bros.

FATHER
12. Name Feliks Dudzinski
13. Birthplace Poland

MOTHER
14. Maiden Name Bronislawa Korythowski
15. Birthplace Poland

16 (a) Informant Mr Felips Dudzinski
(b) Address 230 S. Callington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary (Cem.)
Location Baltimore County

18 (a) Funeral director Mrs Mary Welby
(b) Address 401 S. Chester Street

19 (a) (Date rec'd by registrar) (b)

MAR 16 1944

Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1944, at 8 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1943 to March 13 1944 and that I last saw him alive on March 13 1944

Immediate cause of death: Acute Cardiac Failure with Pulmonary Edema — Duration: 12 hours

Due to: Rheumatic Heart Disease — Duration: 3 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2413 E Monument St Date signed 3/16/44

15139 — 56841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G 15138 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore 3

(If outside city or town limits, write RURAL and give town)

(d) Street No. 153 N. Patterson Pk. Av.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Constantine Mercinko or Constantine Marcinho

3 (b) If veteran, name war

3 (c) Social Security Account No. yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1901

8. AGE: Years	Months	Days	If less than one day
42	4	15	hr min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Night Clerk

11. Industry or business Balt. News & Post.

FATHER — 12. Name Stanislaus Mercinko

13. Birthplace Poland

MOTHER — 14. Maiden Name Anna Pawelczyk

15. Birthplace Poland

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18 (a) Funeral director John M Weber

(b) Address

19 (a) (Date received by registrar) MAR 16 1944 (b) Huntington Undertaking Co., Inc.

VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 — 1944, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8- 1944 to 3-14- 1944 and that I last saw him alive on 3-14- 1944.

Immediate cause of death: pulmonary Tbc.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not performed

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Daniel Ehrlich

Address 4940 Eastern Ave Date signed 3-15-44 M. D.

G 15134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1627

G 15134 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609 N Charles St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 12 - 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 N Charles St (If rural give location)
(e) Citizen of foreign country? -No- (Yes or No)
If yes, name country -

3 (a) FULL NAME Mary Evans Maynard

3 (b) If veteran, name war no
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Elisha H. Maynard
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) about 1854

8. AGE: Years abt 89 | Months 90 - | Days - | If less than one day: hr. min.

9. Birthplace Baltimd (Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER 12. Name Thos. G. Evans
13. Birthplace Baltimd

MOTHER 14. Maiden Name Caroline T. Thomas
15. Birthplace Baltimd

16 (a) Informant Miss Mary Pabst (niece)
(b) Address W. Belona Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimd

18 (a) Funeral director Sullivan Mem'l Co.
(b) Address 108 W Monument

19 (a) Date of receipt MAR 16 1944 Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29/1943 to 3/14/1944 and that I last saw her alive on 3/14/44 19

Immediate cause of death Cardiac failure — Duration: 6 mos.

Due to old age

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. B. Steele MD

Address 1435 Maryland Ave Date signed 3/15/44 M. D.

G 15135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

✓ G 15135 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3045 St Paul St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 12-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town ✓ Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3045 St Paul St (If rural give location)
(e) Citizen of foreign country? —No— (Yes or No) If yes, name country

3 (a) FULL NAME Ida Elizabeth Carling

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 5 1854

8. AGE: Years 90 | Months 1 | Days 9 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

FATHER 12. Name Michael Carling
13. Birthplace Penna

MOTHER 14. Maiden Name Elizabeth Fauss
15. Birthplace Penna

16 (a) Informant Mrs Ida B Shank (niece)
(b) Address 3045 St Paul

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave - City.

18 (a) Funeral director STEWART & COMPANY
(b) Address (W. F. WOODEN SUC.) 105 N. NORTH AVENUE
Huntingtown Williams, Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1944 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1944, to 3/14 1944 and that I last saw her alive on 3/14 1944.

Immediate cause of death. acidosis — Duration 3 days

Due to arteriosclerosis - bronchopneumonia

Due to both feet

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary D McCarty M. D.
Address 37 W Preston St Date signed 3/15/44

VS 116

MAR 16 1944

G 15136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 15136 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Brambleton Rd.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7-15
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Brambleton Rd (If rural give location)
(e) Citizen of foreign country? —No— (Yes or No)
If yes, name country

3 (a) FULL NAME. Lydia Shaw (LYDIA MEYERS SHAW)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edmund Shaw
6 (c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) October 29/72

8. AGE: Years	Months	Days	If less than one day
71	4	16	17 hr. min.

9. Birthplace Phila. Pa (Town, county, and state)
10. Usual Occupation House Keeper
11. Industry or business Care of the Home

FATHER
12. Name Lewis Myers
13. Birthplace Phila. Pa

MOTHER
14. Maiden Name ~~Myers~~ Todd
15. Birthplace Phila. Pa

16 (a) Informant L. M. Shaw
(b) Address Poughkeepsie N.Y.
17 (a) entombment (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville
18 (a) Funeral director Sherwood Memorial Co.
(b) Address 108 W Monroe,
19 (a) (Date rec'd by registrar) MAR 16 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944. at 1:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1944. to Mar. 15 1944, and that I last saw her alive on Mar. 15 1944.

Immediate cause of death	Duration
Cerebral Apoplexy	3 days
Due to Hypertension	2 yrs
Due to Arteriosclerosis	
Due to	
Other Conditions Cholecystitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Sherman A Ward M. D.
Address 2401 Manhattan Av. Date signed 3/15/44

G 15137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15137 Registered No. 122B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. Valley Road Catonsville (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Clara, Knott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Edward T. Knott
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1880

8. AGE: Years	Months	Days	If less than one day
64	1	2	hr. min

9. Birthplace Baltimore County Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward ~~Boore~~ Beare
13. Birthplace Baltimore county Md

MOTHER
14. Maiden Name Jane Blakeley
15. Birthplace Baltimore county Md

16 (a) Informant Helen Driscoll (daughter)
(b) Address 6231 Fairdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 17/43 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road
(c) Huntington Williams M.D.

MAR 16 1944 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 12:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1944, to March 15 1944, and that I last saw her alive on March 14 1944.

Immediate cause of death Peritonitis — Duration

Due to Volvulus c strangulation of small Intestine

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb 20/44 • March 13, 1944

Major findings of operation: Volvulus - Strangulated Bowel

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature A. L. Raffucci - Asst. M. D. M. D.
Address St. Agnes Hosp. Date signed 3/15/44

VS 150

G 15138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§3a

Registered No. G 15138

Type or print PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3307 Southern Ave.
(c) Hospital or institution:

27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Southern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH J. KRAMER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1891

8. AGE: Years	Months	Days	If less than one day
53	0	24	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name Rudolph J. Kramer
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Schmidt
15. Birthplace Switzerland

16 (a) Informant Mr. Erwin I. Kramer
(b) Address 3307 Southern Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Mar. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lowenhaw Funeral Home
(b) Address 7401 Belair Road

MAR 16 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1944 at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1940 to Mar 15 1944, and that I last saw h[illegible] alive on Mar. 14 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Essential Hypertension	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Sawyer, M.D.
Address 4808 Harford Rd. Date signed 3/16/44

VS 150

G 15139

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 15139 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Druid Hosp

(c) Hospital or institution: North Street

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a State Md b County Balto

c City or town (If outside city or town limits, write RURAL and give town)

d Street No. Unk (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Gale, Alphaeus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day hr.	min.
72				

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Unknown

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-44 (month) (day) (year)

(c) Cemetery or crematory Good Shepherd

Location Ellicott City Md

18 (a) Funeral director C. Washington

(b) Address Ellicott City Md

19 (a) MAR 16 1944 (Date rec'd by local reg.) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1944, to 3/2 1944, and that I last saw h alive on 3/2 1944.

Immediate cause of death Cardiac failure — Duration

Due to Myocardial infarction

Due to Arteriosclerotic heart dis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: Coronary thr. dis. with myocardial infarction

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Akeman M. D.

Address Druid Hosp. Date signed 3/8/44

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 15140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 N. Port St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 N. Port St. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Anna MArousek

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife James Marousek.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11 1879.

8. AGE: Years 65 Months 2 Days 3 If less than one day hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Anton Marousek.
13. Birthplace Czechoslovakia.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Czech.

16 (a) Informant daughter-Mrs. Hilda Blank.
(b) Address 800 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/1944. (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer.
Location Belair Rd.

18 (a) Funeral director C. E. Schimunek
(b) Address 2601 E. Madison St.

19 MAR 16 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1944, at 2:30 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive Cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 3/14/44

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓ G 15141 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 S. Paca St.
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 S. Paca St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Annie Sophie Wagner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frederick M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1871

8. AGE: Years	Months	Days	If less than one day
72 yrs.	9	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Casper Meisel
13. Birthplace Germany

MOTHER
14. Maiden Name Miller
15. Birthplace Baltimore

16 (a) Informant Joseph Wagner (son)
(b) Address 829 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

MAR 16 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1944 to March 13, 1944, and that I last saw her alive on March 13, 1944.

Immediate cause of death Diabetes Mellitus — Duration 4 yrs

Due to

Due to

Other Conditions Arthritis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Casserd M. D.
Address 514 Drury Lane Date signed 3/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 15142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G 15142 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 No Bentalow St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

15-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 No Bentalow St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Kronthal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Wht

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 Months Days If less than one day hr min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER - FATHER
12. Name ~
13. Birthplace Austria
14. Maiden Name ~
15. Birthplace Austria

16 (a) Informant Jacob L. Kronthal
(b) Address 1806 N. Bentalow St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Cleadale
Location Franklyn Ave

18 (a) Funeral director Jacob Kairo Inc
(b) Address 1439 E. Balto. St

19 (a) (b)

MAR 16 1944
VS 150

Registrar

Director Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 19 44 at 4 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 44 to 3-16 19 44 and that I last saw h alive on 3-16 19 44

Immediate cause of death
Acute cardiac failure

Due to Pneumonitis.

Due to Coronary Thrombosis

Other Conditions Arteriosclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. E. Needle M. D.

Address 1314 - N. North Ave Date signed 3/16/44

G 15143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G 15143

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Miller

3 (b) If veteran, name war no

3 (c) Social Security Account No. 215-01-7577

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Alberta

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) June 15 1911

8. AGE: Years [illegible] Months 8 Days 25 If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Ship Builder

11. Industry or business Bethlehem Fairfield

FATHER
12. Name Edward Miller
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Lewis
15. Birthplace Va.

16 (a) Informant Alberta Miller (wife)
(b) Address 804 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md.

18 (a) Funeral director Chas. H. Corkran
(b) Address 512 Carrollton Ave. Remington Station, Baltimore, Md.

19 (d) MAR 16 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11- 1944, at 7 45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet wound of abdomen involving common iliac artery
Due to and intestines.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-10-44 at 8:15 P. M.
(b) Where did injury occur? 1030 Sterling St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Bullet

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 3-11-44

G 15144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 6

G Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 28
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Windbourne Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Catherine Potter

3 (b) If veteran, name war W | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Harry E. Potter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26 1904

8. AGE: Years	Months	Days	If less than one day
39	3	24	hr. min

9. Birthplace Reisterstown, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Geo. Hoyle
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Molly Joyce
15. Birthplace Md

16 (a) Informant Harry E Potter
(b) Address 626 Windbourne
17 (a) Burial (b) Date thereof 3/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loud Burial Grounds
Location Loud Md
18 (a) Funeral director Milburn Cook
(b) Address 1217 E Cold St
19 (a) MAR 16 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1944, at 8.05 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1944, to 3/15 1944, and that I last saw h alive on 3/15 1944.

Immediate cause of death	Duration
respiratory failure	
Due to meningitis	4 d.
Due to meningococcus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed 3-16

G 15145 Webster. G 15145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calhoun & Fayette Sts.

(c) Hospital or institution: Franklin Square Hosp. 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 6

(If outside city or town limits, write RURAL and give town)

(d) Street No. 32 W. 25th St.

(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Thomas Holliday Webster, Md.

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Mary Catherine Webster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 07 1856

8. AGE: Years	Months	Days	If less than one day
87 87	10	27	hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Dealer

11. Industry or business: Lumber

FATHER

12. Name: John H. Webster Jr

13. Birthplace: Deale Island Md

MOTHER

14. Maiden Name: Fanny Lewis

15. Birthplace: Deale Island Md

16 (a) Informant: Lt. Thos. H. Webster 3rd

(b) Address: 3718 Woodbourne Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof: 3/17/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~: London Park

Location: Balto. Md.

18 (a) Funeral director: William Cook Inc

(b) Address: St. Paul St

MAR 16 1944

19 (a) (Date received by registrar) (b) Name: William Cook

VS 8 For H-J. Medical Examiner Released by Med. Examiner.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14-1944 at 12 30 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12-1944 to 3-14-1944 and that I last saw him alive on 3-14-1944

Immediate cause of death Bilat. Bronchial Pneumonia — Duration

Due to Benign Pros. Hyp.

Due to 7A. Left Femur

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 3/9/44

(c) Where did injury occur? Balto. (City or town) Md. (County) Md. (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Fell out of chair

23. Signature Howard A. Lusby M. D.

Address Franklin Sq. Hosp Date signed 3/17/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 1514 450223 BALTIMORE CITY HEALTH DEPARTMENT G 15146
Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town TOWSON
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 VIRGINIA AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Louis
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-2-89

8. AGE: Years	Months	Days	If less than one day
54 44	3	12	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Louis Harvey
13. Birthplace Md

MOTHER
14. Maiden Name Angelia
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL 3/16/44

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cemetery
Location Balto. Co.

18 (a) Funeral director Archibald A. Gaddis
(b) Address 2101 McCulloh St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MAR 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 14 1944 at 10.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1944 to MAR 14 1944 and that I last saw h/M alive on MAR 14 1944.

Immediate cause of death	Duration
pulmonary hemorrhage	
Due to Aneurysm of Thoracic Aorta & rupture into bronchus	
Due to Syphilis	
Other Conditions Cavitation, Pneumonia Type P Lobar Pneumonia LLL (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Cencer M. D.
Address J Hopkins Date signed 3-16

Dr. Eugene L. Pusagno 234 E. Baltimore St

G 15147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15147

Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 314 N. Hilton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 N. Hilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Roof

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ Elmer C. Roof

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Jan 30th 1884

8. AGE: Years	Months	Days	If less than one day
60	1	14	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name James T. Daily
13. Birthplace Unknown

MOTHER
14. Maiden Name Ruth Kratz
15. Birthplace Balto. Md.

16 (a) Informant Elmer C. Roof
(b) Address 314 N. Hilton St.

17 (a) Burial (b) Date thereof 3/16/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) MAR 16 1944 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th 1944 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Daily 1, 1943 to March 14 1944, and that I last saw h~~er~~ alive on March 13, 1944.

Immediate cause of death Cerebral hemorrhage — Duration 24 hrs 5 mos.

Due to

Due to

Other Conditions Diabetes Mellitus — 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Pusagno M. D.

Address 234 Drury Lane Date signed 3/16/44

G 15148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 15148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2213 SIDNEY AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 SIDNEY AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANORE SMITH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM.	WHITE	WIDOW

6 (b) Name of husband or wife WILLIAM SMITH.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL-12 186

8. AGE: Years	Months	Days	If less than one day
82	11	3	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation SWINDELL BROS
11. Industry or business GLASS WORKS

FATHER
12. Name NOT KNOWN.
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant JACOB B SWINDELL
(b) Address 2213 SIDNEY AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-18-44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO MD

18 (a) Funeral director Bernard C. Hasle
(b) Address 121 E. West St

19 MAR 16 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 15. 1944. at 3.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1944. to March 15 1944.
and that I last saw h[illegible] alive on March 14 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration 2 Months
Due to Intermediate C.V.D — Duration ??
Due to Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schmied
Address 2301 Ames Ave Date signed 3/16/44

VS 150

G 15149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G 15149 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution St. Joseph's Hosp. 9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1901 E. 31st St. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME MICHAEL WILLINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife Wanda

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) April 14 - 1874

8. AGE: Years	Months	Days	If less than one day
69	10	29	hr. / min.

9. Birthplace Bath Md. (Town, county, and state)

10. Usual Occupation Retired (U.S. Moment)

11. Industry or business

FATHER 12. Name Thomas Willinger

15. Birthplace U.S.A.

MOTHER 14. Maiden Name Gertrude Liff

15. Birthplace U.S.A.

16 (a) Informant Wanda Willinger

(b) Address 1901 E 31st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Leonard Bergh

(b) Address 1305 Harford Rd

18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14- 1944 at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16- 1944 to 3-14- 1944 and that I last saw him alive on 3-14- 1944

Immediate cause of death Carcinoma of larynx with metastases to brain — Duration

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Thomas Brennan, M.D. M. D.

Address St. Joseph's Hosp. Date signed 3-14-44

G 15150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G 15150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N Paca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Garland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C D	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1941

8. AGE: Years	Months	Days	If less than one day
3			hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Garland
13. Birthplace SC

MOTHER
14. Maiden Name Viola Wheeler
15. Birthplace S.C.

16 (a) Informant Mother
(b) Address 521 N. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)

(c) Cemetery or crematory Lake City
Location South Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 924 Druid Hill Ave. Huntington Williams, Md.

MAR 16 1944
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1944, to 3/15 1944, and that I last saw him alive on 3/15 1944.

Immediate cause of death (a) 1st & 2nd degree burns of face, arms, buttocks, and legs. — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3/12/44 at 10 P.M.
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury exploded oil stove

23. Signature William D. Lynn M. D.
Address University Hospital Date signed 3/15/44

VS 150

Approved: H. L. Wollen Weber M.D. 3/16/44
Co. Coroner Ernest Eichorn M.D.

G 15151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15151 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 E. 29th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 E 29th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry F. Gerlach

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-3414

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 - 469

8. AGE: Years	Months	Days	If less than one day
74	7	13	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired Hub Tailor
11. Industry or business

FATHER
12. Name John Gerlach
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Dahl
15. Birthplace Germany

16 (a) Informant Mrs Marie Gerlach
(b) Address 1803 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director Leonard Hunt
(b) Address 3 W. Saratoga St.

19 (a) MAR 16 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944 at 9:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 to March 16 1944, and that I last saw h[illegible] alive on March 16 1944.

Immediate cause of death Arteriosclerosis Myocardial failure — Duration 10 yrs 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur Stevens, M.D.
Address 1738 E. 28th St. Date signed 3/16/44

G 15152

Grave #2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 15152 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Lundahn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-90

8. AGE: Years	Months	Days	If less than one day
53	6	9	hr. min.

9. Birthplace Sweden (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name Emile Lundahn
13. Birthplace Sweden

MOTHER
14. Maiden Name Anna Olsen
15. Birthplace Sweden

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAR 16 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 16 1944 (b) Huntington Williams, M.D. Registrar
(Written record by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1944 8:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1944 to Feb 21 1944 and that I last saw him alive on Feb 21 1944

Immediate cause of death Lobar pneumonia — Duration

Due to pneumococcus type I

Due to ? advanced thr. pulmonary

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Bernington M.D.
Address JHH Date signed 2-21

VS 180

G 15153 X G 15153

450816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 9-5

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Michigan (b) County .....

(c) City or town Lansing (If outside city or town limits, write RURAL and give town)

(d) Street No. 324 W. Hillsdale (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3 (a) FULL NAME Eloise H. Rose

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife John Rose

6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) 5-16-23

8. AGE: Years 20 | Months 10 | Days — | If less than one day: hr. ..... min. .....

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business .....

FATHER

12. Name N. L. Hightower

13. Birthplace N. C.

MOTHER

14. Maiden Name Ida Adams

15. Birthplace S. C.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal ✓ Burial (Burial, cremation, or removal) (b) Date thereof March 16 1944 (month) (day) (year)

(c) Cemetery or crematory Dundee

Location Dundee, Michigan

18 (a) Funeral director Burgee Funeral Home

(b) Address 1231 Falls Road

MAR 16 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16-44 1944, at 12:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAR. 10 1944, to MAR. 16 1944, and that I last saw HER alive on MAR 16 1944.

Immediate cause of death Respiratory Failure

Due to Chronic Progressive Glomerular Nephritis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

Duration: 1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Wm. S. Sprunt III M. D.

Address Johns Hopkins Hospital Date signed 3-16-44

G 15154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 15154 / 89a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Broadway & Fairmount Street

(c) Hospital or institution: Church Home Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3/4 mo.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Lutherville (If outside city or town limits, write RURAL and give town)

(d) Street No. near Baltimore (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Litzinger, Mrs. Emma Catherine

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Charles H. Litzinger

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct. 20. 1892

8. AGE: Years	Months	Days	If less than one day
51	4	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name John H. Sullivan

13. Birthplace Baltimore Maryland

MOTHER

14. Maiden Name Mary M. White

15. Birthplace Baltimore Pennsylvania

16 (a) Informant Husband

(b) Address above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18. 1944 (month) (day) (year)

(c) Cemetery or crematory Maryland Memorial Park

Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) (Date rec'd by reg.) MAR 16 1944 (b) Huntington Valley, Md. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1944, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15, 1944, to → 19 , and that I last saw her alive on March 15, 1944.

Immediate cause of death Respiratory failure

Due to ~~Hemorrhage~~ Increased intracranial pressure

Due to Meningitis

Other Conditions Mastoiditis (rt.) Otitis Media.

(Include pregnancy within 3 months of death)

Date of operation December 1943

Major findings of operation: Sinusitis

of autopsy: Meningitis, Mastoiditis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles Lyman Hatch M. D.

Address Date signed

Approved: 3/16/44 Howard J. Tyndall M.D. per. Robert Lee Graham M.D.

G 15155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G 15155 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2120 Chelsea Terrace
(c) Hospital or institution:

15-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie P. Gossage

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Wm. T. Gossage
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 7, 1872

8. AGE: Years	Months	Days	If less than one day
71	11	8	hr. min.

9. Birthplace Easton, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Thomas W. Price
13. Birthplace Easton, Md.

MOTHER
14. Maiden Name HESTER ANDREWS,
15. Birthplace Easton, Md.

16 (a) Informant Mrs. James E. Rogers
(b) Address 3518 Rolling Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 16 1944

MEDICAL CERTIFICATION 10.05

20. DATE OF DEATH March 15, 1944 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to March 15 1944 and that I last saw h~~im~~er alive on March 15 1944.

Immediate cause of death Cerebral Hemorrhage and paralysis

Due to Arteriosclerosis (advanced)

Due to

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 days
?
about 2 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S. Tibbitt M. D.
Address 220 Garrison Blvd Date signed March 10/44

G 15156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

193D Registered No. G 15156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 636 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Arther

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1866

8. AGE: Years	Months	Days	If less than one day
77	9	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business

FATHER
12. Name John Arther
13. Birthplace Ireland

MOTHER
14. Maiden Name Eliza Jane Weir
15. Birthplace Ireland

16 (a) Informant Mr. Richard E. Bolden
(b) Address 636 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Ramsburg
(b) Address 4510 Liberty Heights Ave.

MAR 16 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to 3/14/44 and that I last saw her alive on 3/14/44.

Immediate cause of death Myocarditis — Duration 1 year

Due to Pyelitis, Abnl Pelvis

Due to Arterio Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 4013 Edmondson Ave Date signed 3/16/44

G 15157 pres

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15157 Registered No.

1107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~902 N. Chester St~~

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city limits, write RURAL and give town)

(d) Street No. 902 N. Chester St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bernadette Hunt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	wh.	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1943

8. AGE: Years | Months 5 | Days 22 | If less than one day: hr min

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Charles Hunt

13. Birthplace Balto

MOTHER

14. Maiden Name Marie Holub

15. Birthplace Balto

16 (a) Informant Charles Hunt

(b) Address 902 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Frank Grack Son

(b) Address 900 N. Chester St

19 (a) Huntington Williams M.D. (Signature of registrar)

(Date received by registrar)

MAR 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944 at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1944 to 3/15 1944 and that I last saw h er alive on 3/15 1944.

Immediate cause of death Resp. Arrest — **Duration**

Due to aspiration Pneumia?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Murray Weiner M.D.

Address Date signed

G 15158

450328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15158

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town ..... (If outside city or town limits, write RURAL and give town)

(d) Street No. 7713 Mearl Rd. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Orby Lyon

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Lottie

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 5-17-97

8. AGE: Years	Months	Days	If less than one day
46			hr ..... min

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation machine Shop

11. Industry or business .....

MOTHER / FATHER

12. Name William Lyon

13. Birthplace Pa.

14. Maiden Name Mary Cagney

15. Birthplace Pa.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-44 (month) (day) (year)

(c) Cemetery or crematory .....

Location Cemetery Pa

18 (a) Funeral director .....

(b) Address .....

MAR 16 1944 (b) .....

(Date rec'd by registrar) (Registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1944 to Mar. 16 1944 and that I last saw him alive on Mar. 16 1944.

Immediate cause of death Lobar pneumonia

Duration .....

Uraemia.

Due to Pyohydronephrosis - Rt.

Absence of left kidney.

Due to .....

Other Conditions Cutaneous ureterostomy

(Include pregnancy within 3 months of death)

Date of operation Nov. 1943

Major findings of operation: Ureter tract infection with stricture

of autopsy: same as above.

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury .....

23. Signature Russell B. Roth

Address Johns Hopkins Hosp Date signed 3/16/44 M.D.

G 15159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G 15159
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6306 Belair Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6306 Belair Road (If rural, give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Owen Lusby Morris

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 2-1881

8. AGE: Years 64 | Months 5 | Days 11 | If less than one day: hr. min

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation —
11. Industry or business None

FATHER
12. Name William E. Morris
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Albaugh
15. Birthplace Maryland

16 (a) Informant Samuel F. Morris
(b) Address 6306 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director J. B. Hippert & Son
(b) Address 1311 Eutaw Place

MAR 17 1944

(Date received by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13th 1944 at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from March 12 1944, to March 13 1944, and that I last saw him alive on March 10 44.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to Hypertensive Cardio-Vascular disease

Due to —

Other Conditions Cerebral degeneration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M.D. M.D.
Address 4706 Harford Road Date signed 3/14/44

15160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 15160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles A. Rohlfing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Della H. Rohlfing
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 25, 1890

8. AGE: Years	Months	Days	If less than one day hr.	min
53	11	19		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business Wholesale Pharmaceutical

FATHER
12. Name John Rohlfing
13. Birthplace Baltimore

MOTHER
14. Maiden Name Salome Schneider
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs. Della Rohlfing
(b) Address 929 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave.

19 (a) MAR 17 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [redacted] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH [redacted] Cerebral hemorrhage, spontaneous.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fraham M.D.
Medical Examiner
Date signed March 15, 1944

VS 151

G 15161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15161 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Your correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2517 Guilford Ave.

(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 3

(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:

a State Md. County none

City or town Baltimore (If outside city or town limits, write RURAL and give town)

d Street No. 2517 Guilford Ave. (If rural give location)

e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME Maud Kenly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1871

8. AGE: Years 72 | Months 9 | Days 21 | If less than one day hr min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name F. Frank Kenly

13. Birthplace Md.

MOTHER 14. Maiden Name Mary E. Murphy

15. Birthplace Md.

16 (a) Informant Mrs. Katherine K. Hupman

(b) Address Cockeysville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Lorraine

Location Windsor Mill Road

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) MAR 17 1944 (b) (Registered by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944, at M

21. I certify that death occurred on the date above stated, that I attended deceased from March 13, 1944. to March 16 1944. and that I last saw her alive on Mar. 16, 1944

Immediate cause of death: Right Lobar Pneumonia — Duration: 1 week.

Due to

Due to

Other Conditions: Chronic myocarditis (Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank H. Ogden M. D.

Address 2701 Calvert St. Date signed Mar 16/44

Huntington Williams, M.D.

G 15162 ✓ G 15162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1615 Park Ave.

(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:

a. State Md. b. County

c. City or town Baltimore, (If outside city or town limits, write RURAL and give town)

d. Street No. 1615 Park Ave. (If rural give location)

e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME May Long Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow

6 (b) Name of husband or wife Geo. F. Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/26/1866

8. AGE: Years	Months	Days	If less than one day
77	11	20	hr min

9. Birthplace Marion, Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Thomas W. Long

13. Birthplace Md.

MOTHER 14. Maiden Name Louisa V. White

15. Birthplace Md.

16 (a) Informant Louisa Sinnott

(b) Address 3815 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/44 (month) (day) (year)

(c) Cemetery or crematory Location St. Pauls Cemy. Marion, Somerset Co. Md.

18 (a) Funeral director John O. Mitchell Sons Co.

(b) Address 1900 Eutaw Place

19 (a) MAR 17 1944 (Date filed by registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1944 to Mch 15 1944, and that I last saw her alive on Mch 14 1944

Immediate cause of death

Due to Myocardial insufficiency

Due to hemorrhage from a ruptured Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration
1 wk.
few yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

c. Where did injury occur? (City or town) (County) (State)

d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

e) Means of injury

23. Signature M Bauman Md M. D

Address 2200 Garrison Blvd. Date signed 3/16/44

15163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15163
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1415 W. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 -
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 W Lombard St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) **FULL NAME** Irene L. Bouchell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Edgar L. Bouchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1876

8. AGE: Years	Months	Days	If less than one day
67	3	24	hr. min.

9. Birthplace Royal Oak Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Nicholas Leonard
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Edgar L. Bouchell
(b) Address 1415 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md

18 (a) Funeral director Geo. L. Beyer Jr.
(b) Address 512 Hollins St

19 MAR 17 1944 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15-1944, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1944 to 3-15-1944, and that I last saw her alive on 3-15 1944.

Immediate cause of death: Coronary thrombosis Sudden death — Duration

Due to ?

Due to

Other Conditions Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris B. Schreiber M. D.
Address 575 Fulton Ave Date signed

3164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42E

G 15164
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct name, color or race, sex, and other information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3036 Belmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 Belmont Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E. Tompkins

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Walter W. Tompkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1874

8. AGE: Years	Months	Days	If less than one day
69	11	8	hr. min

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William Volkman
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Listman
15. Birthplace Germany

16 (a) Informant Miss Margaret E. Tompkins
(b) Address 3036 Belmont Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 18, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave. Balto., Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) MAR 17 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1944 at 8.30 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 26 1944 to Mar 13 1944, and that I last saw her alive on Mar 13 1944

Immediate cause of death: Hypertensive Cardio-vascular Disease — Duration ?

Due to Arterio sclerosis — ?

Due to

Other Conditions Aortic Sclerosis, Acute Bronchitis — ?

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (Give city or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Carey R. Ortlieb, M. D.
Address 326 W. Lombard St Date signed 3/16/44

G 15165

AB-86793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15165 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1527 Winchester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Boy Nettles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4-1944

8. AGE: Years | Months | Days | If less than one day: 4 hr min

9. Birthplace: Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Violet Williams
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 3-16-44 (month) (day) (year) 9 AM
(c) Cemetery or crematory B. C. Hosp
Location 4940 Eastern ave,

18 (a) Funeral director B C. Hosp
(b) Address 4940 Eastern ave.,

19 MAR 17 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1944 at 7:10 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 3/4 1944 to 3/8 1944.
and that I last saw h/ alive on 3/8 1944

Immediate cause of death Cerebral Hem. Lapse — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl R. Kinsey M. D.

Address B. C. H. Date signed 3/9/44

G 15166

SL - 86068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

87 D

Registered No. G 15166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 27

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1811 N. Caroline St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Ruby Hardman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Dr. Samuel Hardman.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1890

8. AGE: Years	Months	Days	If less than one day
53	6	24	hr. min.

9. Birthplace N. Y. (Kingston) (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Lee Hornbeck

13. Birthplace N. Y.

MOTHER

14. Maiden Name Lottie Merrihew

15. Birthplace N. Y.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park National

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 MAR 17 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1944, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1944 to 3-16 1944, and that I last saw h-- alive on 3-16 1944

Immediate cause of death

? Multiple Sclerosis

Due to Spinal Cord Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
-

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald Baker

Address Balto City Hosp Date signed 3-16-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167 / 115 C

G 15167

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: 3629 Manchester Ave.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3629 Manchester Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GLADYS M. WITMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-22-8199

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Stanley F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1905

8. AGE: Years	Months	Days	If less than one day
39	1	23	hr. min.

9. Birthplace Parksley, Va. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Remington Putnam

FATHER 12. Name John F. Mason

13. Birthplace Parksley, Va.

MOTHER 14. Maiden Name Katie Taylor

15. Birthplace Chestertown, Md.

16 (a) Informant Mr. Stanley F. Witman

(b) Address 3629 Manchester Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) MAR 1 7 1944 (Date received by local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 14, 1944 at 7:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28th 1944 to Mar 14th 1944, and that I last saw h alive on Mar 14th 1944

Immediate cause of death Heart Failure — Duration 2 hrs

Due to Postmortem Abscess — 4 days

Due to

Other Conditions Excessive Mucus — 1 week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. E. Poulton M. D.

Address 3904 Gannon Blvd Date signed 3/15/44

G 15168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G 15168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 N. Appleton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 N. Appleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GARRETT RILEY BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	216-14-3017

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Pauline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10, 1888.

8. AGE: Years	Months	Days	If less than one day
55	5	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Davidson Chemical Co.

FATHER
12. Name George W. Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Hackett
15. Birthplace Md.

16 (a) Informant Mr. George Thompson
(b) Address 727 N. Appleton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 17 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 15, 1944, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1943, to Mch 15 1944, and that I last saw h im alive on Mch 13 1944.

Immediate cause of death: Carcinoma of Stomach — Duration: four yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Jan 1944
Major findings of operation: Carcinoma was inoperable
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W Barnard Kood M. D.
Address 2200 Jessamine Blvd Date signed 3/15/44

15169

HEALTH DEPARTMENT—CITY OF BALTIMORE

15169

CERTIFICATE OF DEATH

83A

27-16

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 Cold Spring Lane St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. If of foreign birth 72 yrs. mon. ds.

If U. S. Veteran specify WAR

2. FULL NAME Mary Goldmann

(a) Residence: No. 2503 Cold Spring Lane St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Goldmann

6. DATE OF BIRTH (month, day, year) Dec. 7, 1871

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Krakow, Austria

FATHER

13. NAME Aaron Goldman

14. BIRTHPLACE (city or town) (State or country) Austria

MOTHER

15. MAIDEN NAME Not Known

16. BIRTHPLACE (city or town) (State or country) Austria

17. INFORMANT Daughter Mrs. Ellen Sadler

(Address) 2503 Cold Spring Ln

18. BURIAL, CREMATION, OR REMOVAL

Place Balto. Hebrew Date March 19 44

19. UNDERTAKER Sol Levinson Bros

(Address) 1124-26 W. Mt. Royal

MAR 17 1944 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 17, 1944

22. I HEREBY CERTIFY, That I attended deceased from Dec 14 1943, 19..., to March 17, 1944.

I last saw him alive on March 17, 1944. Death is said to have occurred on the date stated above, at 5:55 a.m.

The principal cause of death and related causes of importance were as follows:

	Duration of onset
Uremia - nephritis	?
Other contributory causes of importance: Hypertension	yrs
Apoplexy (Cerebral Hemorrhage)	2 days

Was an operation performed? No Date of

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Herman Oppenheimer M. D.

(Address) 3939 Greenmount Ave

OCCUPATION is very important. See instructions on back of certificate. Exact statements of

15170 — G 15170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 33B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4802 Curtis Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md — County
(b) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4802 Curtis Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline L. Himmel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 - 1881

8. AGE: Years 63 | Months 1 | Days 13 | If less than one day: hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Himmel
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Bauer
15. Birthplace Germany

16 (a) Informant Geo F. Himmel
(b) Address 4802 Curtis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location U. S. Rt. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS MAR 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from None 1944 to 3/15 1944, and that I last saw h[illegible] alive on 3/13 1944

Immediate cause of death: Myocarditis Insufficiency — Duration: Years / Months / Days

Due to Influenza — 5 days

Due to

Other Conditions Diarrhea.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm D. Harka M. D.
Address 1700 Pennsylvania Date signed 3/17/1944

15171 V 6 15171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1638 Jackson St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 Jackson St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amma Louise Kohlhoff Schwanke,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edward Schwanke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1879

8. AGE: Years 64 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name Louis Kohlhoff
13. Birthplace Germany

MOTHER
14. Maiden Name E. Loetz,
15. Birthplace Germany.

16 (a) Informant Mr. Herman A. B. Schwanke,
(b) Address 1638 Jackson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto. City

18 (a) Funeral director C. Bruce Lemmon
(b) Address Park Ave & Mt.

19 (a) MAR 17 1944 (Date rec'd by registrar) (b) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1944 19 . at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 19 44 to March 15 19 44. and that I last saw her alive on March 15 19 44.

Immediate cause of death
Cerebral Hemorrhage
Due to
Cerebral Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
2 days
Indef.

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. O. Campbell M. D.
Address 1644 Hanover St. Date signed 3/16/44

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G 15172 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1003 Bayard St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1003 Bayard St (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Grill

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary Grill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26. 1863

8. AGE: Years	Months	Days	If less than one day
81	0	1920	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Oyster Shucker

11. Industry or business

FATHER 12. Name William Grill

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Schuman

15. Birthplace Baltimore, Md

16 (a) Informant Margaret M. Grimes

(b) Address 1003 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 18. 1944 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. G. Co. Md

18 (a) Funeral director Mrs. Mrs. John M. Trifle & Son

(b) Address 801 W. Fayette St

19 (a) (Date rec'd by registrar) (b)

MAR 17 1944 Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16 1944 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to Mar 16 1944, and that I last saw h alive on 3/16/1944

Immediate cause of death

(a) Embolism Pneumonia

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days
10 Yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard D Grimes M. D.

Address 1 W Saratoga St Date signed

G 15173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 15173

Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 528 N. Bruce (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nettie Greenfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-24-02

8. AGE: Years	Months	Days	If less than one day
41	7	20	hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Davis Walker

13. Birthplace Md

MOTHER

14. Maiden Name Gertie Brown

15. Birthplace Md

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15, 1944 (month) (day) (year)

(c) Cemetery or crematory Hopkins Chapel Cem.

Location Howard Co. Md.

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 322 N. Eutaw St.

19 (a) (b)

Date received MAR 17 1944 Registrar

VS Form 10a Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 14 1944, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 14 1944 to Mar 14 1944 and that I last saw her alive on Mar 14 1944.

Immediate cause of death	Duration
Respiratory failure	1 hr
Due to Cerebral edema and hemorrhage	12 hrs
Due to Hypertension	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral edema & hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Harrington M.D.

Address Johns Hopkins Hosp. Date signed 3-14-44

G 15174

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G 15174 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 350 N Gay
(c) Hospital or institution:
5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 350 N Gay (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Scanlan

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-9937

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida Castle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/13/1868

8. AGE: Years 75 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Canada (town, county, and state)

10. Usual Occupation Steel Contractor

11. Industry or business

FATHER
12. Name David Scanlan
13. Birthplace Canada

MOTHER
14. Maiden Name Celia McNulty
15. Birthplace Dufond,

16 (a) Informant Mrs Ida Scanlan
(b) Address 350 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director John Agne
(b) Address 218 Hughes St

19 (a) MAR 17 1944 (Date received) Harrington Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1944 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1944 to 3-13 1944, and that I last saw him alive on 3-13 1944.

Immediate cause of death Hypertensive heart condition — Duration Unknown

Due to Hypertension or myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur W. Kar M. D.
Address 3862 Dolfield Ave Date signed 3-17-44

Arthur W. Kar

G 15175 ✓ G 15175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits write RURAL and give town)

(d) Street No. 823 Rutland Ave (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Roscoe Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1937

8. AGE: Years 7 | Months | Days | If less than one day: hr min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name Roscoe Taylor

FATHER 13. Birthplace —

MOTHER 14. Maiden Name Alverta

MOTHER 15. Birthplace —

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location C. A. County Md.

18 (a) Funeral director Mrs L. A. Elliott & Dgt

(b) Address 1124 N. Caroline St.

19 (a) MAR 17 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 14 1944 at 5 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to . 19 , and that I last saw h alive on 19 .

Immediate cause of death: Convulsions of epileptic type — Duration .....

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at .. M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Elizabeth Conrad M. D.

Address Johns Hopkins Date signed 3-15-44

G 15176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 15176 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 Latrobe Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1617 Latrobe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Dortch Jr ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	9		hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name John Henry Dortch Sr
13. Birthplace N. C.

MOTHER 14. Maiden Name Cora Bullock
15. Birthplace N. C.

16 (a) Informant John Henry Dortch
(b) Address 1617 Latrobe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.G. - County Md.

18 (a) Funeral director Mrs. Robert A. Elliott Dept
(b) Address 1299 N. Caroline St

MAR 17 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1944 at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobular Pneumonia.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenmuller M.D.
Medical Examiner.
Date signed March 16 1944.

VS 151

G 15177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 15177 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Beverly Eggleston (Eggleston)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: baby

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12/43

8. AGE: Years | Months: 3 | Days: 4 | If less than one day: hr min

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Eggleston
FATHER 13. Birthplace Va

MOTHER 14. Maiden Name Louise Meredith
MOTHER 15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md
18 (a) Funeral director Mrs R. Elliott Dgt
(b) Address 1129 N. Carlin St.
19 (a) 1944 (Registered by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944 at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16 1944 to Mar. 16 1944 and that I last saw him alive on Mar 16 1944.

Immediate cause of death: Respiratory Failure
Due to: Pneumonia
Due to:
Other Conditions: Meningitis
(Include pregnancy within 3 months of death)

Duration: 2 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Wilson M.D.
Address Johns Hopkins Date signed 3/16/44

C 15178

Reg. No. 75702

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

C 15178
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr- 7mos-16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr-8mos-16days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 618 S. Bethel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George WEGRZYN or Kojesch Wangryn

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
about 53	?	?	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd.,

18 (a) Funeral director W. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) MAR 17 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1944 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1942 to 3-16 1944 and that I last saw h[illegible] alive on 3-16 1944.

Immediate cause of death Lobular pneumonia — Duration ?
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None above

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mahne M. D.
Address B. C. H. Date signed 3/17/44

VS 150

G 15179 Evans. ✓ G 15179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 Lamdale ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1628 Lamdale ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Bernard Evans

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M
5. Color or race Col
6 (a) Single, married, widowed, or divorced. S.
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/9/1911

8. AGE: Years 32 Months 2 Days 7 If less than one day hr. min.

9. Birthplace Balto md (Town, county, and state)

10. Usual Occupation Potter

11. Industry or business

FATHER
12. Name Samuel Evans
13. Birthplace md

MOTHER
14. Maiden Name Annie Johnson
15. Birthplace md

16 (a) Informant Frances Evans
(b) Address 1628 Lamdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pressman St

19 (a) Date received MAR 17 1944 (b) Registrar Huntington Mobbins, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1944, at 3 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1944, to 3-16 1944, and that I last saw h alive on 19 .

Immediate cause of death acute congestion of lungs.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Duration 2 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. H. Pryor M.D.
Address 1576 W. Lanvale Date signed 3-17-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 51B

G 15180
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Harvey Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Milton H. Meekins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	widowed

6 (b) Name of husband or wife Birdie A. Beadette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1872

8. AGE: Years	Months	Days	If less than one day
71	11	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Business Manager
11. Industry or business Marine Engs. Bent Axe

FATHER
12. Name Samuel Meekins
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Smith
15. Birthplace Md.

16 (a) Informant Family
(b) Address 2708 Harvey Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-18-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Frederick Ave.

18 (a) Funeral director Jas. F. McCauley
(b) Address 1508 Fort Ave.

19 (a) (b)
(Signature of registrar) Registrar
MAR 17 1944
VS 15a Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944 at 10 39 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1944 to 3-15 1944 and that I last saw him alive on 3-13 1944.

Immediate cause of death	Duration
Carcinoma of Prostate	
Due to	
Due to	
Other Conditions Hypertensive C. V. D. Bilat. Hydronephrosis + pyonephrosis	

Date of operation Ca. of Prostate
Major findings of autopsy Metastatic Ca, Ca. of prostate, Bilat. hydro + pyonephrosis

PHYSICIAN - 3/14/44
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Hagan
Address Univ. Hosp. Date signed 3/15/44

G 15181 ✓ G 15181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B2

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3906 Parkside Drive

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md., (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3903 Parkside Drive (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JENNIE HELEN LEIMBACH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Tracy Leimbach

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1883

8. AGE: Years	Months	Days	If less than one day
30	5	24 23	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name John Silknitter

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Not Known

15. Birthplace Pennsylvania

16 (a) Informant Tracy Leimbach

(b) Address 3906 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address North Ave. & Broadway

19 (a) MAR 17 1944 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14 1944 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2nd 1943 to Mar 14 1944 and that I last saw h[illegible] alive on Mar 13 1944.

Immediate cause of death: a) Uremia — Duration: 1 Mo.

Due to: Carcinoma of Uterus Rectum & Bladder — Duration: Four 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. H. Thomas M. D.

Address 3136 Kenfor Rd Date signed 3/18/44

G 15182 ✓ X G 15182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 4
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Gabriel Rettaliata

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Male

6 (b) Name of husband or wife Pauline Rettaliata
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, ~~April~~ 5th 1884

8. AGE: Years	Months	Days	If less than one day
59	11	10	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Real Estate dealer
11. Industry or business

FATHER
12. Name Chas. R. Rettaliata
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Poggi
15. Birthplace Italy

16 (a) Informant Pauline Rettaliata
(b) Address Elkridge Md #27

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/18/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director Wellsman Cook Inc
(b) Address 1217 St. Paul St

MAR 17 1944 Huntington Williams, M.D. (Date received) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 15 1944 at 339 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1944 to 3-15 1944 19
and that I last saw him alive on 3-15-44 19

Immediate cause of death
Miliary tuberculosis
Pott's disease
Due to Tbc meningitis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: 3-15-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address 3-15-44 Date signed 3-15-44
University Hospital

G 15183

BALTIMORE CITY HEALTH DEPARTMENT G 15183
Registered No.

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Page is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 325 E 30th St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET I WIMMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 April 1885

8. AGE: Years	Months	Days	If less than one day
58	11	7	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John W. Rice
13. Birthplace Virginia

MOTHER
14. Maiden Name Alfonza Barrett
15. Birthplace Virginia

16 (a) Informant Miss Helen Wimmer
(b) Address 325 E. 30th St.

17 (a) Burial (b) Date thereof 3/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director Wm Cook Inc
Address 1217 St. Paul St

MAR 17 1944

19 (a) Washington Williams, M.R.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 March 1944 at 5:16 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 15 March 1944 to 16 March 1944, and that I last saw her alive on 16 March 1944.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Hypertensive Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Dell III M. D.
Address Union Memorial Hosp Date signed 3-16-44

G 15184 ✓ G 15184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette St.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 E. Montgomery St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie Fox

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-23-1860

8. AGE: Years	Months	Days	If less than one day
83	2	23	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business House wife

FATHER
12. Name Conrad Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Henry Fox
(b) Address 318 N. Franklintown Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18 1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md
18 (a) Funeral director Wilbert Funeral Home
(b) Address 1212 Eutaw Pl
19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/44 19 at 7:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3/13/44 19 , to 3/16/44 19 , and that I last saw her alive on 3/16/44 19 .

Immediate cause of death: Myocardial Weakness — Duration
Due to: Senility
Due to: Generalized Arterio-Sclerosis
Other Conditions: Contusion of Occipital Region & Superficial Wounds
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3/14/1944
(c) Where did injury occur? 219 E. Montgomery St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury slipped & fell down stairs
23. Signature Dr. Louis Stutek
Address Franklin Square Hosp. Date signed 3/16/44 M.D.

VS 3

Approved: C. T. Lubinski per M. Rivet Asst Registrar 3/18/44

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G 15185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15185

Registered No. 94a

71 - 86973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 826 N. Fulton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Hengst

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Flora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April ? 1864

8. AGE: Years	Months	Days	If less than one day
79 80 ?	? 11	?	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation On City Relief

11. Industry or business

FATHER 12. Name Ruben Hengst

13. Birthplace Penn.

MOTHER 14. Maiden Name Charlotte Laher

15. Birthplace Penn.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director Loving, Byers

(b) Address 5005 Old Frederick Rd

MAR 17 1944 Huntington Williams M.D.

(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1944, to 3-16 1944, and that I last saw him alive on 3-16 1944.

Immediate cause of death	Duration
Probable Cerebral Embolus	Immediate
Due to Mural Thrombi	?
Auricular Fibrillation	
Due to Bogis. Gangrene Lt Leg	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald B. Webb M. D.

Address Balto City Hosp Date signed 3-16-44

G 15186 ✓ G 15186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Dayone ave (If rural give location)
(e) Citizen of foreign country? Bayonne (Yes or No)
If yes, name country

3 (a) FULL NAME Grover Smith

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1886

8. AGE: Years	Months	Days	If less than one day
58	—	3 5/16	hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ambrose Smith
13. Birthplace W. Va

MOTHER 14. Maiden Name Mary Bland
15. Birthplace W. Va

16 (a) Informant Leon Kline
(b) Address 413 Madison St. Portsmouth Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/44 (month) (day) (year)
(c) Cemetery or crematory
Location Franklin, W. Va

18 (a) Funeral director Howard N. Blight Jr
(b) Address 4914 Belair Road

19 (a) MAR 17 1944 (Date received by Registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17- 1944, at 8 15 A M

21. I certify that I took charge of the remains described above, held an Inspection - Injury Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull

Due to

Other Conditions Traumatic Compression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/1
(a) Date of injury 3-15-44 at 4.30 P. M.
(b) Where did injury occur? Bel Air Rd & Glenarm Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by automobile

23. Signature Howard J. Sheldon M.D.
Medical Examiner
Date signed 3-17-44

Please write the causes of death clearly and legibly.

G 15187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15187 Registered No. 183

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5517 Pioneer Drive.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5517 Pioneer Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gayle Bond

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
—	—	Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1941

8. AGE: Years	Months	Days	If less than one day
2	6	28	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Bond
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Francis
15. Birthplace Balto. Md.

16 (a) Informant Albert Bond
(b) Address 5517 Pioneer Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Taylor ave

18 (a) Funeral director Howard W. Blight Jr.
(b) Address 4914 Belair Road

19 (a) (b) Huntington Williams, M.D.
(Registered by register) Registrar

MAR 17 1944
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16- 1944 at 2.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-16-44 at 12:30 P. M.
(b) Where did injury occur? Herring Run Stream 400 ft. west of Pioneer Drive.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Found drowned Herring Run

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 3-17-44

G 15188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12/a

G 15188 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 176 S. Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 176 S Arlington Ave (If rural give location) ?
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Minnie Roediger

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1880

8. AGE: Years	Months	Days	If less than one day
64	0	23	4 hr. min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name William Roediger
13. Birthplace France

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Charles G. Dorsch
(b) Address 176 S. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18-44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location

18 (a) Funeral director Roth & Sons
(b) Address Roth & Stricker Sts

19 (a) MAR 17 1944 Huntington Williams Building
(Date rec'd by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944, at 4 40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 28 1944, to March 13 1944, and that I last saw her alive on March 13 1944.

	Duration
Immediate cause of death: Myocardial Infarction	
Due to: Generalized arteriosclerosis C. V. Disease	?
Due to:	
Other Conditions: Pulmonary edema Dropsy (Include pregnancy within 3 months of death)	2 months

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan M. D.
Address 24 W. Fulton Ave Date signed 3/17/44

Age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

G 15189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Bresmont ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Bresmont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Mahn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Godfrey S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 6 - 1869

8. AGE: Years 74 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Penn (Town, county, and state)

10. Usual Occupation Home
11. Industry or business

FATHER 12. Name Robert Emanuels
13. Birthplace Ger

MOTHER 14. Maiden Name Angeline Pfarr
15. Birthplace Penn

16 (a) Informant Mrs Blanche Garner
(b) Address 2903 Bresmont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director John C. Moran
(b) Address 3900 Baltimore St

19 (a) MAR 17 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944, at 1245 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to March 1944, and that I last saw her alive on Mar 16 1944.

Immediate cause of death Coronary Thrombosis

Duration 2 hrs.

Due to Hypertension & arteriosclerosis

Duration Several years

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams M.D.
Address 31 E Mount Ave. Date signed 3-17-44 M.D.

VS 3

Please answer all questions as carefully and completely as possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13 a

G 15190
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 St Paul St - Rooms
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Ruscher (Carl Hugo George Ruscher)

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Otteilia M. Ruscher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1887

8. AGE: Years	Months	Days	If less than one day
56	11	16	hr. min.

9. Birthplace Koenigslutter, Germany
(Town, county, and state)
10. Usual Occupation Manager
11. Industry or business ?

FATHER
12. Name George Ruscher
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Wulke
15. Birthplace Germany

16 (a) Informant Mrs. O. M. Ruscher
(b) Address Jenkintown, Pa.

17 (a) Removal (b) Date thereof 3/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CHELTEN HILLS
Location Philadelphia, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 17 1944 (b) Huntington Williams Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17-1944, at 9:05 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Cardio - vascular Renal

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Nicholson M.D.
Medical Examiner.
Date signed 3-17-44

JO #65580 G 15191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G 15191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos. 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Penrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Elmer Shipley~~ Elmer Arthur Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1869

8. AGE: Years 74 | Months 4 | Days 15 | If less than one day hr min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Bar Keeper

11. Industry or business Hotels

FATHER
12. Name William H. Shipley (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Sarah Hewitt (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Friends Burial Ground
Location Baltimore, Md.

18 (a) Funeral director Miller Lamorale
(b) Address 4510 Liberty Heights Ave.

19 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar) MAR 17 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1944, at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1943 to 3-16 1944.
and that I last saw him alive on 3-16 1944.

Immediate cause of death: Generalized Carcinomatosis — Duration: 3 mo +
Due to: Operable Carcinoma of Colon
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnold B Stott
Address Balto City Hosp Date signed 3-16-44 (M/D)

Every item of information should be carefully supplied. Type or WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 15192
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4500 Block Liberty Hgts Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4819 Norwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie E. Fahrney Katie L. Fahrney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Dr. P. D. Fahrney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) November 11, 1882

8. AGE: Years	Months	Days	If less than one day
61	3	5	hr. min

9. Birthplace Keedysville, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel Avey
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Ecker
15. Birthplace Maryland

16 (a) Informant Miss Lora U. Fahrney
(b) Address 4819 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Fahrney's Church Cemetery
Location Washington Co., nr Boonsboro, Md.

18 (a) Funeral director Miller Lamond
(b) Address 4510 Liberty Heights Ave.

MAR 17 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams Sig R

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1944 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Enquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.c. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions Arteriosclerotic Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Thurston J. Talbert M.D. Medical Examiner
Date signed 3/16/44

G 15193

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 N. Robinson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
a. State Md. b. County
c. City or town Baltimore (If outside city or town limits, write RURAL and give town)
d. Street No. 513 N. Robinson St (If rural give location)
e. Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Rodman (Rodimounas)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-1895

8. AGE: Years	Months	Days	If less than one day
49		12	hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Chipper

11. Industry or business Bethlehem Steel Co

FATHER
12. Name George Rodimonas
13. Birthplace Lithuania

MOTHER
14. Maiden Name Unknown
15. Birthplace Lithuania

16 (a) Informant Catherine Rodimonas
(b) Address 513 N. Robinson

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross R.C. Cem
Location Govans Md

18 (a) Funeral director Neuhardt Bros
(b) Address 900 N. Chester St Huntingtown Williams, Md

MAR 17 1944
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 43 to March 16 19 44
and that I last saw h alive on March 16 19 44.

Immediate cause of death
Carcinoma of stomach
(a) metastasis

Duration 9 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex E. Sikorsky M. D.
Address 939 Cathedral St Date signed 3/16/44

G 15194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15194 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 708 Harney St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ralph C. Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-21-32

8. AGE:	Years	Months	Days	If less than one day
	11	2 3	26	hr. min.

9. Birthplace Md, Baltimore (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

MOTHER | FATHER

12. Name George E. Lewis

13. Birthplace Balto, Md.

14. Maiden Name Mary R Wiegard

15. Birthplace Balto., Md.

16 (a) Informant Records. JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27 1944 (month) (day) (year)

(c) Cemetery or crematory Cedarhill Cem

Location Arcoma Md

18 (a) Funeral director H. Howard Evans

(b) Address 2 Charles St (30)

MAR 17 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17 1944 at 12.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1944 to Mar 17 1944 and that I last saw h alive on Mar 17 1944

Immediate cause of death: Uremia

Due to: Chronic nephritis

Due to:

Other Conditions: Cerebral Hemorrhage - Myocarditis (Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul E. Wilson M. D.

Address Johns Hopkins Hosp. Date signed 3-17-44

15195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 15195
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glyndon
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Central Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Manger, Mr John Thomas

3 (b) If veteran, name war –

3 (c) Social Security Account No. 215-07-5519

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Hattie R. Manger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1 1886

8. AGE: Years 57 | Months 11 | Days 16 | If less than one day: hr. min.

9. Birthplace Pikesville, Md.
(Town, county, and state)

10. Usual Occupation Clerk Fidelity

11. Industry or business Warehouse

FATHER
12. Name Manger, Mr John
13. Birthplace Maryland

MOTHER
14. Maiden Name Van Winkle, Mrs Joffie
15. Birthplace Maryland

16 (a) Informant Mrs Hattie R. Manger
(b) Address 204 Central Ave, Glyndon, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 21-44 (month) (day) (year)

(c) Cemetery or crematory ~~Antrim~~ Druid Ridge Cem.
Location Balto Co., Md

18 (a) Funeral director J. F. Glenn Sons
(b) Address Reisterstown Md.

MAR 18 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1944, to March 17 1944 and that I last saw him alive on March 17 1944.

	Duration
Immediate cause of death: Air Emboli	3 days
Due to Thoracoplasty - 1st Stage Post Operative	3 days
Due to Pulmonary Tuberculosis - Rt	9 months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation March 13 1944

Major findings of operation: Pulmonary Tuberculosis - Rt

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Cuffley M. D.
Church Home + Hospital
Address Baltimore, Md Date signed 3-17-44

G 15196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15196 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3710 Hickory Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Hickory Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Patterson.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow.

6 (b) Name of husband or wife Frank H. Patterson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1864

8. AGE: Years	Months	Days	If less than one day
79	5	5	hr min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Elias Frank
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Franklin Patterson
(b) Address 3102 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 18/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Emanuel R. Sonneborn
(b) Address 615-17 Eastern Ave

MAR 18 1944 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940 to March 15 1944 and that I last saw h e alive on March 15 1944.

Immediate cause of death: Cerebral Thrombosis — Duration: 2 days
Due to Hypertension CVD — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Tumanelli M. D.
Address 3711 Falls Rd
Date signed 3-15-44

G 15197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 15197

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Caroline

(c) City or town Denton (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Wm Henry Brown Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1941

8. AGE: Years	Months	Days	If less than one day
2	7	24	hr. min.

9. Birthplace Denton, Caroline County, Md (Town, county, and State)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Wm Henry Brown

13. Birthplace Md

MOTHER 14. Maiden Name Helen Dalford

15. Birthplace Md

16 (a) Informant Father

(b) Address Denton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)

(c) Cemetery or crematory Denton Cem.

Location Denton, Md.

18 (a) Funeral director Wm. J. Buckman & Son

(b) Address North & Penna Ave Baltimore Md

(Signature of undertaker or agent) Huntingtown Williams, Mgr

MAR 18 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1944, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1944, to 3/18 1944.

and that I last saw him alive on 3/18 1944.

Immediate cause of death Bronchopneumonia

Due to Bronchopneumonia

Due to Foreign body in lung

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/16

Major findings of operation: Bronchoscopy. Small foreign body removed from left lung

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 3/16 M

(c) Where did injury occur? Denton (City or town) Caroline (County) Md (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?

(e) Means of injury Aspirated piece of peanut

23. Signature W. D. Lynn M. D.

Address University Hospital Date signed 3/19/44

G 15198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15198 Registered No.

YA-83721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos., 4days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 E. Biddle (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Huber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1st 1880

8. AGE: Years	Months	Days	If less than one day
63	11	15 13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frederick Huber
13. Birthplace Md.

MOTHER
14. Maiden Name Susan ? Harryman
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18th 1944 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location E North Ave Ext

18 (a) Funeral director Leo G. Jacob
(b) Address 1701-03 N Patterson Park ave

19 MAR 18 1944 (Date rec'd by Registrar) (b) Huntington Williams ave

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1944 at 4:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1943 to 3-14 1944, and that I last saw h[illegible] alive on 3-14 1944.

Immediate cause of death Cardiac failure — Duration

Due to Hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattre M. D.
Address B.C.-11 Date signed 3-16-44

G 15199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. G 15199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 N. Linwood Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 N. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH HELLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George C. Heller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1854

8. AGE: Years	Months	Days	If less than one day
89	5	23	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant George A. Heller
(b) Address 2406 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ullrich Funeral home
(b) Address 2008 Orleans St.

MAR 18 1944 (Date rec'd by registrar) Armstrong for Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944. at 20. A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 - 1944. to March 16 1944. and that I last saw her alive on March 16 1944.

Immediate cause of death Uremia — Duration 3/14/44
cardio-vascular-renal (5yrs)
Due to arterio-sclerosis - 5 yrs.
Due to
Other Conditions Had intertrochanteric fracture right femur - Dec 29-1943 with O.R.
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Krumrein M. D.
Address 722 N. Kenwood Ave Date signed 3/17/44

Approved: Robert Lee Graham M.D. 3/18/44

G 15200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G 15200 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 S. CONKLING ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 S. CONKLING ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DARLENE JEAN SIMONS

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 20, 1944

8. AGE: Years	Months	Days	If less than one day
	21	27	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name CREED G. SIMONS
13. Birthplace WEST. VIRGINIA

MOTHER
14. Maiden Name ETHEL YINGLING
15. Birthplace BALTIMORE MD

16 (a) Informant ETHEL SIMONS
(b) Address 202 S. CONKLING ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location PARKVILLE MD

18 (a) Funeral director ULLRICH FUNERAL HOME
(b) Address 2001 ORLEANS ST.

19 (a) MAR 18 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 17 1944, at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1944 to Mar 17 1944, and that I last saw her alive on Mar 16 1944.

Immediate cause of death: Congenital malformation of Heart (with chronic cyanosis)
Due to —
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
...
...
...
...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Lythgoe M. D.
Address 431 S. Bolton St. Date signed 3/17 1944

G 15201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

G 15201 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2122 McCulloh

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2122 McCulloh St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nellie E. Merrill

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Frank Merrill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Accomac Co. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Watson

13. Birthplace Va

MOTHER 14. Maiden Name Hettie Conquest

15. Birthplace Va

16 (a) Informant Frank Merrill

(b) Address 2122 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 20 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director James A Otaye

(b) Address 1142 Westfield St

19 (a) MAR 18 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 16 1944, at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 19[illegible] to 3/16 19[illegible], and that I last saw h[illegible] alive on 3/16 19[illegible]

Immediate cause of death: Cerebral Apoplexy — Duration

Due to Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Burkhalter M. D.

Address 239 Dumont Ave Date signed 3/17-44

15202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 15202

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2560 Woodbrook ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2560 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Holly

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-27-44

8. AGE: Years	Months	Days	If less than one day
0	-	21	20 hr. min.

9. Birthplace Balt. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Marion Holly
13. Birthplace Md.

MOTHER
14. Maiden Name Gertrude ?
15. Birthplace Md.

16 (a) Informant Marion Holly
(b) Address 2560 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co.

18 (a) Funeral director Saml. W. Thomas & Co
(b) Address 638 N. Eutaw

MAR 18 1944
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17- 1944, at 11 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bronchopneumonia

Due to

Other Conditions Upper Respiratory Infection

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-17-44

VS 151

G 15203

YA-85230

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15203 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos., 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)
Street No. 863 N. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Meyers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1857

8. AGE: Years	Months	Days	If less than one day
86	9	20 21	hr min

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? ? (d)
13. Birthplace Md.

MOTHER
14. Maiden Name Teresa ? (d)
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/44 (month) (day) (year)
(c) Cemetery or crematory Lacepedeaux
Location Lorraine Ave Ro
18 (a) Funeral director J. J. Daley Light St.
(b) Address
19 (a) (Date rec'd by registrar) MAR 18 1944 (b) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1944 at 3:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1943 to 3-14 1944, and that I last saw h alive on 3-12 1944.

Immediate cause of death: Intracranial hemorrhage — Duration: 2 days
Due to: Artery Hypertension Arteriosclerosis
Due to: Heart Disease ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Paul Habbe

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Habbe M. D.
Address B. C. H. Date signed 3-15 1944

G 15204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

G 15204
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Leppard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 10, 1900

8. AGE: Years	Months	Days	If less than one day
44	0	5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Leppard
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ann Leppard
(b) Address 1815 Vine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March, 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore Maryland

18 (a) Funeral director Joseph A. Smith
(b) Address 4 & N Mount Street

19 (a) MAR 18 1944 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 15, 1944 1:00 P.M.
(b) Where did injury occur? Gilmor & Mulberry Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Struck by street car

Signature Robert L. Heatwole M.D. Medical Examiner.

Date signed March 15, 1944

15205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56 E

G 15205 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette and John Streets

(c) Hospital or institution: Hospital for the Women of Maryland 147

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 hours

(e) Length of stay in Baltimore (yrs., mos., or days) 27 hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Ann Arundel

(c) City or town RURAL, Pasadena P.O. (If outside city of town limits, write RURAL and give town)

(d) Street No. Mountain Road (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME THELMA MARIE EVANS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ James N. Evans

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) March 1, 1904

8. AGE: Years	Months	Days	If less than one day hr.	min.
40	0	14		

9. Birthplace Brooklyn, Maryland (Town, county and state)

10. Usual Occupation House wife

11. Industry or business Home

FATHER

12. Name William Helmstetter

13. Birthplace Brooklyn, Maryland

MOTHER

14. Maiden Name Louise Reinhardt

15. Birthplace Brooklyn, Maryland

16 (a) Informant James N. Evans, husband

(b) Address Pasadena, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18 1944 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cemetery

Location Brooklyn Md

18 (a) Funeral director William M Mareck

(b) Address 715 Light St.

19 (a) MAR 18 1944 (Date received by Registrar) Huntington Williams Mort

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 7 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1944 to March 15 1944, and that I last saw her alive on March 15 1944.

Immediate cause of death: Heart failure — Duration: 8 hours

Due to Operation: Supra vaginal hysterectomy & appendectomy

Due to

Other Conditions ?? Congenital heart disease ?? — Duration: Life

(Include pregnancy within 3 months of death)

Date of operation March 15, 1944

Major findings of operation: Myomatous uterus - Normal appendix

of autopsy: Not obtained

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank W Rigby Jr M. D

Woman's Hospital Date signed

Baltimore, Md. 3-15-44

G 15206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15206 Registered No. 46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 S. MONTFORD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE MD. (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 S. MONTFORD AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK KRUG

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: BARBARA KRUG
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): APRIL 3-1868

8. AGE: Years 75 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)
10. Usual Occupation: LABORER
11. Industry or business:

FATHER
12. Name: PHILIPH KRUG
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: BARBARA KRUG (WIFE)
(b) Address: 706 S. MONTFORD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)
(c) Cemetery or crematory: HOLY REDEEMER
Location: BELAIR ROAD

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S. WOLFE ST.

MAR 18 1944 (Date rec'd by registrar)
(a) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 17 1944 at 10AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944. to March 17 1944
and that I last saw h[illegible] alive on — 19

Immediate cause of death: Coronary Thrombosis

Duration:

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E A Schumunk M. D.
Address 842 S East Ave Date signed 3-17-44

approved by Howard J. Masseo, M.D.

G 15207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G 15207

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 S. Sharp Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sidney Mitcher (MITCHER)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Ikkonia Mitcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-1908

8. AGE: Years	Months	Days	If less than one day
35	11	20	hr. min.

9. Birthplace Prospect, Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Samuel Mitcher
13. Birthplace Va.

MOTHER
14. Maiden Name Hester Harvey
15. Birthplace Va.

16 (a) Informant Ikkonia Mitcher
(b) Address 800 S. Sharp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 18 (day) 44 (year)
(c) Cemetery or crematory Prospect Va.
Location Prospect Va.

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 [illegible] (b) Huntingtown Hilltown Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16- 19kk, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Subarachnoid Hemorrhage, Spontaneous.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulder M.D.
Medical Examiner.
Date signed 3-17-44

MAR 18 1944 (Date Rec'd by Local Reg.)

VS 151

Gussie Brakton

G 15208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15208 Registered No.

1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2504 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Jennie Brayton

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Col	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day hr.	min.
54				

9. Birthplace Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas Cain

13. Birthplace unknown

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Queen Brayton

(b) Address 2504 Druid Hill Ave

17 (a) Burial (b) Date thereof 3/22/44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. G. Kelly

(b) Address 1303 Preastman St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MAR 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944, at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1944 to March 17 1944, and that I last saw h[illegible] alive on March 17, 1944.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to Cardio-Vascular Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address 803 N Bond Date signed

G 15209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 15209

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1626 Harlem Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1626 Harlem Ave. (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Finks

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1874

8. AGE: Years 69 | Months 10 | Days -3 | If less than one day hr. -19 min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name John Schuyler

13. Birthplace Baltimore Co. Md.

14. Maiden Name Ellen Johnson

15. Birthplace Baltimore Co. Md.

16 (a) Informant Blanche Dixon

(b) Address 1626 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George W. Howard

(b) Address 1634 Druid Hill Ave.

19 (a) MAR 18 1944 (Local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 · 14 1944 at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3 · 9 1944 to 3 · 14 1944 and that I last saw h e alive on 3 · 14 1944

Immediate cause of death: Uremia Lobar Pneumonia — Duration: 1 day

Due to: Lobar Pneumonia — 6 days

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

25. Signature Wm. LeRoy Levy

Address 1420 E. Chase Date signed 3-17-44

VS 150

15210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 15210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4413 Groveland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4413 Groveland Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME ELIZA JANE GRESSITT

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William M. Gressitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1858

8. AGE: Years	Months	Days	If less than one day
85	5	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name - Irvin
13. Birthplace -

MOTHER 14. Maiden Name -
15. Birthplace -

16 (a) Informant Mr. Mordecai B. Gressitt
(b) Address 4413 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1944, at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1944 to March 15 1944, and that I last saw her alive on March 15 1944.

Immediate cause of death
1) - Broncho-pneumonia — Duration 2 days.
Due to -
Due to
Other Conditions - Arterio-Sclerosis - 5 yrs.
Cardiac - Vascular disease.
(Include pregnancy within 3 months of death)
Date of operation - None
Major findings of operation: - None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature - Earl L. Chambers
Address 4108 Liberty Hts. Date signed 3/17/44 M. D.

G 15211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 15211
Registered No.

Please write plainly with pen or indelible pencil. Do not use typewriter. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 Ryan Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Ryan Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hayward

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1869

8. AGE: Years	Months	Days	If less than one day
74	?	?	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace Ohio

MOTHER
14. Maiden Name Rudd
15. Birthplace Ohio

16 (a) Informant Miss Mary Hicks
(b) Address 1418 Light Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/94 (month) (day) (year)
(c) Cemetery or crematory Mendenwridge Mem. Pk.
Location Balto. Md.

18 (a) Funeral director M. J. Johnson & Son
(b) Address Balto, Md.

MAR 18 1944 at [illegible]
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1944, at 10:20 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Muldaur M.D.
Medical Examiner.
Date signed March 18, 1944.

G 15213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15213
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Monkton (If outside city or town limits, write RURAL and give town)
(d) Street No. Big Falls Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Grant V. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sadie (Nee Jones)

6 (c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.) Mar 18, 1879

8. AGE: Years 65 | Months 11 | Days 27 | If less than one day: hr. min.

9. Birthplace: Balto. Co. Md. (Town, county and state)

10. Usual Occupation: Track Worker

11. Industry or business: Penn. R.R.

FATHER
12. Name: John Thomas
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mrs. Maude Ulrich
(b) Address: Monkton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory: St. Judes
Location: Newfield (Monkton P.O.) Md

18 (a) Funeral director: Landon M. Brooks
(b) Address: Sparks, Md.

19 MAR 18 1944 (c) Huntington Indiana
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1944, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 15 1944 M.
(b) Where did injury occur? On R.R. under Guilford Ave. Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place (While at work) Yes
(d) Means of injury: Struck by train.

23. Signature: Robert Lee Graham M.D.
Medical Examiner.
Date signed March 18 1944

15213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

✓ G 15213 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 Ashland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Ashland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Alt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.30,1879

8. AGE: Years	Months	Days	If less than one day
64 yrs	11	16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Alt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Fried Denhofer
(b) Address 4642 Warren St.N.W.Wash.D.C.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) ~~XXXXX~~ or crematory Greenmount
Location Baltimore, Maryland.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

MAR 18 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944 at 9.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to March 16 1944 and that I last saw her alive on March 16 1944.

Immediate cause of death: Cerebral Hemiplegia (left) following Embolism — Duration 8 hours

Due to: Carcinoma of the Stomach — 1 yr.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E Monument St Date signed 3/17/44

G 15214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 15214 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 W. CROSS. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 W Cross st (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. BERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	White	WIDOW

6 (b) Name of husband or ~~wife~~ William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4, 1877

8. AGE: Years	Months	Days	If less than one day
67	1	13	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name GEORGE H. HARTMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY E. HIGDON
15. Birthplace BALTIMORE MD

16 (a) Informant Madeline Herr.
(b) Address 1217 W. CROSS St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 21 / 44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick ave.

18 (a) Funeral director Ambrose, Inc
(b) Address Franklintown Rd
MAR 18 1944

19 (a) [illegible] Huntington Williams Mortician
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1944 at 130A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1943 to 3-17 1944 and that I last saw her alive on 3-17 1944.

Immediate cause of death	Duration
Acute Cardiac Failure	1da
Due to Hypertensive Cardio Vascular Renal Disease	5Yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph A. Lankart, M.D.
Address 1217 Washington Blvd Date signed 3-23-44

VS 3

15215 FERNANDIS ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 15215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 Druid Hill ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Druid Hill ave. (If rural give location)
(e) Citizen of foreign country? md. (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Elizabeth Fernandis

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife J. Evans Fernandis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25 1882

8. AGE: Years 62 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name John L. Hitchens
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Acila Williams
15. Birthplace Balto. Md.

16 (a) Informant J. Evans Fernandis
(b) Address 1912 Druid Hill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Md.

18 (a) Funeral director Wm. J. Chatmon Jr.
(b) Address 6009 Prescott ave.

19 (a) Received MAR 18 1944 Huntington Williams, M.D.
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16-1944 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to 3-16 1944. and that I last saw her alive on 3-16 1944.

Immediate cause of death: Carcinoma & Metastasis

Due to: Primary in Left Breast

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. B. Fuller, M.D.
Address 2033 Druid Hill Date signed 3/19/44

G 15216 ✓ G 15216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 N. Linwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME ANDREW EDWIN BERKLEY

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 213-10-9282

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1887

8. AGE: Years	Months	Days	If less than one day
57	1	20	hr ..... min .....

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business May Co

FATHER
12. Name Charles Berkley
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Heim
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Mae Berkley
(b) Address 206 N. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20. 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

MAR 19 1944 (Date received) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944, at 10 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1943 to March 16 1944 and that I last saw him alive on March 4 1944

Immediate cause of death: myocardial insufficiency — Duration: 1 wk.
Due to: Pulmonary carcinoma — 2 mo
Due to: — 6 mo
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. C. Bothwell
Address 447 N. Kenwood Ave. Date signed 3/17/44 M. D.

G 15217 ✓ G 15217

458926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert Co.
(c) City or town Prince Frederick
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Dares Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Sewell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	black	married

6 (b) Name of husband or wife Effie
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 5-20-91

8. AGE: Years	Months	Days	If less than one day
52	9	28	hr min

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation farmer
11. Industry or business farm

FATHER
12. Name Leonard Sewell
13. Birthplace Md.

MOTHER
14. Maiden Name Rachel Smothers
15. Birthplace Md.

16 (a) Informant Records
(b) Address [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Calvert Co

18 (a) Funeral director P. E. Sewell
(b) Address Prince Frederick Md

MAR 19 1944 (Date received by Registrar) (b) Huntington Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944 at 8 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 1944 to Mar 18 1944 and that I last saw him alive on Mar 18 1944.

Immediate cause of death Peritonitis — Duration

Due to separation of suture, fecal following gastrectomy

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 3/16/44

Major findings of operation: carcinoma of stomach

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Wilson M.D.
Address Date signed 3/18/44

VS 150

450939 G 15218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 87E

G 15218 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1720 N. Appleton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irving Jachobowitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 10-20-06

8. AGE: Years 37 | Months 4 | Days 28 | If less than one day: hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation Erector

11. Industry or business

FATHER 12. Name Samuel Jachobowitz
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Wallman
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)
(c) Cemetery or crematory Beth El Cem
Location New York City
18 (a) Funeral director Jack Levine Inc.
(b) Address 1459 E. Baltimore St

19 (a) MAR 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 18 1944, at 335A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 13 1944, to MAR 18 1944, and that I last saw him alive on MAR 18 1944.

Immediate cause of death: Increased intracranial pressure. — Duration
Due to Unknown cause.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3/14/44
Major findings of operation: Increased intracranial pressure & edema
of autopsy Not done. S. Israel

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol W. Arculeos
Address Sinai Hospital Date signed 3/18/44

G 15219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 D

G 15219 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2833 Chesterfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2833 Chesterfield Ave/ (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MARY ELIZABETH LEWIS

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 277-12-8541B

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Lewis
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) January 1, 1871

8. AGE: Years 73 | Months 8 | Days 17 | If less than one day: hr. min.

9. Birthplace Orange, N. J. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Hardy
13. Birthplace England

MOTHER
14. Maiden Name Clark
15. Birthplace Ireland

16 (a) Informant Robert Lewis
(b) Address 2833 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery or crematory Acacia- Mayfield, Cleveland, Ohio
Location
HENRY SANDER & SONS, INC.

18 (a) Funeral director
(b) Address North Ave. & Broadway

19 (a) MAR 17 1944 (Date rec'd by registrar) Interment in Williamsport MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 5:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to Mch 18 1944 and that I last saw h[illegible] alive on Mch 17 1944.

Immediate cause of death — Duration

Due to Hypertensive Cardio-Vascular Disease — 3 yrs

Due to

Other Conditions Hypertrophic Cirrhosis of Liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fritz J Kinzer M. D.
Address 2700 Harford Rd Date signed Mch 18 1944

VS 150

G 15220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 15220 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 341 S. Smallwood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 341 S Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herman F Rock

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Emma M Rock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 - 185

8. AGE: Years	Months	Days	If less than one day
93	2	15	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name Henry Rock
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mary Schumann
(b) Address 341 S. Smallwood St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore md

18 (a) Funeral director Geo. A. Wagner & Son
(b) Address 457 W. Baltimore St

MAR 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1944 to 3/17 1944, and that I last saw him alive on 3/17 1944.

Immediate cause of death Senility Arteriosclerosis. Hypostatic

Duration

Due to

Due to

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. D. Kitsch M. D.
Address 357 Wellesley Date signed 3/19/44

G 15221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G 15221 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 S. Fremont St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 S. Fremont St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M. Selby

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter S. Selby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6th 1869

8. AGE: Years 75 | Months 2 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Dorunges
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Walter S. Selby
(b) Address 422 S. Fremont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director J. B. Mumpert Son
(b) Address 185 W. Baltimore St

MAR 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1944 to March 16 1944, and that I last saw h[illegible] alive on March 16 1944.

	Duration
Immediate cause of death: Uterine arterio sclerotic cardio-renal disease	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD M. D.
Address 2030 W. Lafayette Ave Date signed 3/18/44

G 15222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 176

G 15222 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene

(c) Hospital or institution: Univ Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 33 Mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto City

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 4406 Iowanda Ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country Russia

3 (a) FULL NAME Kalman Greenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 64 | Months | Days | If less than one day hr. min

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation General Work

11. Industry or business

FATHER 12. Name Abraham Greenberg

13. Birthplace Russia

MOTHER 14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Mr. M. Greenberg

(b) Address 4406 Iowanda Ave

17 (a) Burial Date thereof 3-19-44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Israel

Location Druid Lane

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto St

19 (a) March 18 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17-44 19 , at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1944 to 3-17 1944 and that I last saw him alive on 3-17 1944.

Immediate cause of death: Cranio - cerebral trauma severe — Duration

Due to Fall

Due to

Other Conditions fract ulna rt fract radius rt

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 4/2

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 3-15-44 at 12:05 PM

(c) Where did injury occur? Balto Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Novelty house While at work? yes (Specify type of place)

(e) Means of injury Fell down elevator

23. Signature E. Hampton Hall M. D.

Address Univ Hosp Date signed 3-17-44

YS 180

Approved: Robert Lee Fratum M.D. 3/18/44

G 15223

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15223 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 E. Balto St
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and the county)
(d) Street No. 2510 E Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lehman Roseman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Wht	Married

6 (b) Name of husband or wife Rosa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER	12. Name Nathan
	13. Birthplace Russia
MOTHER	14. Maiden Name Rosa
	15. Birthplace Russia

16 (a) Informant A. J. Roseman
(b) Address 2510 E. Balto. St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-44 (month) (day) (year)
(c) Cemetery or crematory Mikro Kodash
Location Mt Lew Herring Run
18 (a) Funeral director Jack Levin Inc
(b) Address 1139 E. Balto St
19 (a) 3/19/44 (Date rec'd by registrar) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18- 1944 at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13th 1944 to 3/17th 1944 and that I last saw h alive on 3/17th 1944

Immediate cause of death Pulmonary Edema — Duration 9 days
Due to Cardio Vascular Disease — Duration 8,
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. J. Jenkins M. D.
Address 100 N Milton Ave Date signed 3/18/44

VS 160

Please PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15224 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 Harford Rd.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin J. Colleran

3 (b) If veteran, name war: None
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie A. Lenfaeh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1888

8. AGE: Years	Months	Days	If less than one day: hr.	min.
55	3	17		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation General Labor
11. Industry or business Balto. Struct Dept

FATHER
12. Name Martin J. Colleran
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mat Kinnon
15. Birthplace Baltimore Md

16 (a) Informant Mrs Marie A Lenfaeh
(b) Address 2303 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4439 Belair Rd

18 (a) Funeral director Clyde W. Conklin Son
(b) Address 924 E. Lanvale St

19 (a) (Date received by registrar) (b) Registrar

MAR 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 17th, 1944 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1943 to 3/16 1944, and that I last saw him alive on 3/16 1943.

Immediate cause of death Acute Cardiac failure — **Duration**

Due to Ch. myocarditis

Due to Ch. Bronchial asthma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature A. H. Hornstein M. D.
Address 733 Arosmith St Date signed 3/17/44

G 15225

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X G 15225 Registered No. 95a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hos.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City or~~ town A. A Co.
(If outside city or town limits, write RURAL and give town)
Street No. 116 Towsend St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME arlene Matusah

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16-1934

8. AGE: Years	Months	Days	If less than one day
9	8	1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James
13. Birthplace Poland

MOTHER
14. Maiden Name Leona Brown.
15. Birthplace Balto. Md.

16 (a) Informant James Matusah
(b) Address 116 Towsend St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A-A. Co.

18 (a) Funeral director Wm. A. Fialkowski
(b) Address 2007 Eastern ave

19 (a) (Date received by registrar) (b) Registrar

MAR 19 1944
VS 189

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1944, to March 17 1944, and that I last saw her alive on March 17 1944.

Immediate cause of death Cardiac standstill — Duration

Due to Stokes-Adams —

Due to Heart block —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: no gross pathology

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Sinai Hosp. Date signed 3/17/44

G 15226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15226

Registered No. .....

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1735 N. Caroline St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1735 N. Caroline St. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Raymond W. Scherer

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ and or wife Margaret E. Scherer

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1902

8. AGE: Years 41 | Months 11 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business West Disinfecting Co.

FATHER

12. Name John W. Scherer

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Venie M. Weisenbach

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Margaret E. Scherer

(b) Address 1735 N. Caroline St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20, 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave., Balto., Md

18 (a) Funeral director E. Howard Strong

(b) Address 3207 W. North Ave.,

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MAR 19 1944 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

10.00

20. DATE OF DEATH March 16, 1944 at P.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10, 1944 to Mar 16, 1944, and that I last saw h~~im~~er alive on Mar 16, 1944.

Immediate cause of death Chronic Myocarditis — Duration .....

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify home, farm, or place)

(e) Means of injury .....

23. Signature Samuel B. Wolfe

Address 1331 E. Monument Date signed 3-17-44. M.D.

G 15227

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G 15227
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 Reservoir St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 Reservoir St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Rogers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1865

8. AGE: Years	Months	Days	If less than one day
79	2	16	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name James Lloyd Rogers
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Virginia R. Babcock
15. Birthplace Baltimore, Md.

16 (a) Informant Grafton Lloyd Rogers
(b) Address 722 Reservoir St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAR 19 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1943, to Mar 17 1944, and that I last saw h ev alive on Mar 17 1944.

Immediate cause of death Carcinoma of Corpus & Cervix & general metastasis — Duration Before 11/9/43

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-20-43

Major findings of operation: Carcinoma of cervix & metastasis to peritoneum & lung

Date of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas C. Cb Judd M. D.
Address 222 Wendover Road Date signed

G 15228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 15228

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 S SAVAGE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 S. SAVAGE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BABY BOY ROSE

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAR. 18-44

8. AGE: Years | Months | Days | If less than one day: 18 hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name ROBERT ROSE
13. Birthplace FREMONT N.C.

MOTHER
14. Maiden Name HARRIETT A. TALBOT
15. Birthplace ANNAPOLIS MD.

16 (a) Informant ROBERT ROSE (FATHER)
(b) Address 624 S. SAVAGE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 20-44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST

19 (a) MAR 19 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 18 1944, at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1944 to March 18 1944, and that I last saw h[illegible] alive on March 18 1944.

Immediate cause of death Prematurity

Duration 18 Hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J N Davis M.D.
Address Dundalk, Md Date signed 3/19/44

G 15229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15229 Registered No. 52

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 Lemon (Lemmon) St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Lemon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Darcel R. Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Edna C Malonee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 28, 1897

8. AGE: Years	Months	Days	(Less than one day) hr.	min.
46.	6	18		

9. Birthplace Cumberland (Town, county, and state) Maryland

10. Usual Occupation Boiler maker

11. Industry or business B+O. R.R.

FATHER
12. Name Rufus Oliver
13. Birthplace Unknown

MOTHER
14. Maiden Name — Bierman
15. Birthplace unknown

16 (a) Informant Mrs Edna C. Oliver
(b) Address 1722 Lemmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Weiler
(b) Address 1101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 19 44, at 2 P M

21. I certify that I took charge of the remains described above, held an Inquest - Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH. Carcinoma of Prostate & Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester [illegible] M.D.
Medical Examiner.
Date signed 3/16/44

G 15230 ✓ G 15230

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hosp.
(c) Hospital or institution: Wilkens + Calvert
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Clarence Parks
13. Birthplace Virginia

MOTHER 14. Maiden Name Mary Stewart
15. Birthplace Md.

16 (a) Informant Mr Clarence Parks
(b) Address 405 Belvedere ave

17 (a) Buried (b) Date thereof 3/20/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry A. Wetzke
(b) Address 410 Edmondson ave

19 Filed by registrar Huntington Hilliard M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944 at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1944 to March 18 1944, and that I last saw h[illegible] alive on March 18 1944.

Immediate cause of death Premature

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Kaffenberger M.D.
M. D.

Address St. Agnes Hosp. Date signed

G 15231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 15231 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Parks.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Clarence Parks
13. Birthplace Va

MOTHER 14. Maiden Name Mary Stewart
15. Birthplace Md.

16 (a) Informant Clarence Parks
(b) Address 4015 Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Maryland

18 (a) Funeral director Harry H. Wittke
(b) Address 4101 Edmondson Ave

19 (a) (Signature of registrar) (b) Huntington Feb 29 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 3:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1944 to March 18 1944 and that I last saw h alive on March 18 1944.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. A. Kaiser Jr. M.D. M. D.
Address 8 E Fayette St Date signed

LVS 1-40 194

G 15232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 15232 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1523 Druid Hill Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1523 Druid Hill Ave. (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Daly

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1876

8. AGE: Years 68 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Unknown

13. Birthplace

14. Maiden Name Martha Hall

15. Birthplace Baltimore, Md

16 (a) Informant Edith Daly

(b) Address 1523 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland

(b) Address 163 Druid Hill Ave

19 (a) MAR 20 1944 (Registered by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 15 1944 at 7.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1944 to Mch 14 1944 and that I last saw h[illegible] alive on Mch 14 1944.

Immediate cause of death Cardio Vascular Renal Disease — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E B Hughes

Address 1413 Druid Hill Ave Date signed Dec 19-44 1944

15233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15233
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Whitecoat St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Prettyman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Mary Prettyman
6 (c) If give, give age 51 years

7. Birth date of deceased (mo., day, yr.) 4-5-90

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	11	17	12	

9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Argyle and Smithson St.

FATHER
12. Name Henry Prettyman
13. Birthplace Howard Co., Md

MOTHER
14. Maiden Name Annie Anderson
15. Birthplace Carroll Co., Md.

16 (a) Informant Mary S. Prettyman
(b) Address 1203 Whitecoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-44 (month) (day) (year)
(c) Cemetery or crematory St. Lukes
Location Sykesville, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison, Ave.

19 (Date received by registrar) MAR 20 1944 (b) Huntington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944, at 6 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1944, to March 17 1944, and that I last saw h[illegible] alive on March 17, 1944

Immediate cause of death: Encephalitis of Undetermined Etiology — Duration: 4 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. H. Bamford M. D.
Address Provident Hospital Date signed 3/18/44

15234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. G 15234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 S. Caton ave
(c) Hospital or institution: Jenkins Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 S. Caton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary C. Welden

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace West Philadelphia, Penna. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name John Welden
13. Birthplace Ireland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Jenkins Memorial
(b) Address 1000 S. Caton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Son
(b) Address 1827 W. North Ave.

19 (a) Filed MAR 20 1944 (b) Registrar Martin for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944 at 6:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1944 to Mar. 17 1944, and that I last saw her alive on Mar. 16 1944.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Severe essential hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Arthur Rosebery M.D.
Address St. Agnes Hosp. Date signed 3/17/44

VS 180

15235

BALTIMORE CITY HEALTH DEPARTMENT X V G 15235

CERTIFICATE OF DEATH 937

Registered No.

PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Mason Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Oakland (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME IDA ELIZABETH WILLIAMS
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: WILLIAMS
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 17, [illegible]
8. AGE: Years 73 | Months 11 | Days 29 | If less than one day: hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: James Wesley Williams
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Melinda —
15. Birthplace

16 (a) Informant: Mrs. Viola Thompson
(b) Address: Ashland, Balto. Co., Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory: Poplar Meth. Cem. Location: Baltimore Co., Md.
18 (a) Funeral director: John Burns Sons
(b) Address: Towson, Md.
19 (a) [illegible] (b) Huntington Williams, M.D.

MAR 20 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1944, at 9:10 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1944 to March 16 1944, and that I last saw her alive on March 16 1944.

Immediate cause of death: Cardiac Failure
Due to: Arteriosclerotic Heart Disease
Due to:
Other Conditions: Gall bladder adhesions to Duodenum
(Include pregnancy within 3 months of death)
Date of operation 3-7-44
Major findings of operation: Gall bladder adhesions to Duodenum.
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William H. Lyell M. D.
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15236

Reg-16065

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G 15236
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 yrs-7 mos. 10days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Rawlins or John W. Rollins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Harriett F. Rollins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9-1863

8. AGE: Years	Months	Days	If less than one day
80	4	9	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Stephen Brook Rawlins or Rollins
13. Birthplace Va. Port Royal, Va

MOTHER
14. Maiden Name Susan ? Gibbs
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-44 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Baltimore, Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights

MAR 20 1944
(Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1944, at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1927 to 3-18 1944, and that I last saw h[illegible] alive on 3-18 1944.

Immediate cause of death Bronchopneumonia

Duration 7

Due to General alleged Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mattus
Address Baltimore City Hosps Date signed 3/18/44

G 15237

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

G 15237 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 5328 Denmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew R. Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1875

8. AGE: Years	Months	Days	If less than one day
69	1	6	hr. min.

9. Birthplace Tamaqua Pa. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Andrew R. Jackson
13. Birthplace Lehmont, Pa.

MOTHER
14. Maiden Name Katherine Rex
15. Birthplace Tamaqua, Pa.

16 (a) Informant Mrs Andrew R. Jackson
(b) Address 5328 Denmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)
(c) Cemetery or crematory Westminster Com
Location Westminster, Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 (a) MAR 20 1944 (Date rec'd by registrar) (b) Clinton Fillious, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1944, at 6 25 M

21. I certify that I took charge of the remains described above, held an Injury - Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture 3rd-4th Cervical Vertebrae (Broken Neck)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/16/44 at 5:15 P.M.
(b) Where did injury occur? 5328 Denmore Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury Fell down 5 steps

23. Signature [signature] M.D. Medical Examiner.
Date signed 3/17/44

VS 151

G 15238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 15238
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 S. Paca St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S. Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annetta Geppi

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Jos Geppi
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1877

8. AGE: Years	Months	Days	If less than one day
66	7	2	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Jos Cipriano
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Marsilia
15. Birthplace Italy

16 (a) Informant Jos. Geppi
(b) Address 416 S. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Jos. J. Kenny
(b) Address Hollins & Eutaw Sts (Number and street or R.F.D. number, city or town, and State)

MAR 20 1944 (b) 8
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15- 1943. to 3-17-1944.
and that I last saw h alive on 3-15 1944.

Immediate cause of death	Duration
Pulmonary Oedema	1 week
Due to metastatic carcinoma of lung	6 mos.
Due to Carcinoma of breast	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2- , 43
Major findings of operation: adeno-carcinoma of mammary gland infiltrated
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature S. J. Enneis
Address Medical Arts Bldg Date signed 3-19-44 M. D.

15239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/a

G 15239

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Gambord & Green

(c) Hospital or institution: University Hosp. 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d

(e) Length of stay in Baltimore (yrs., mos., or days) 9yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State ✓ (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 796 W Saratoga St. (If rural give location)

(e) Citizen of foreign country? Yes or No ✓

If yes, name country

3 (a) FULL NAME Reecia Floyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
33			hr. min

9. Birthplace Gastonia N. C. (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER 12. Name John Floyd

13. Birthplace N.C

MOTHER 14. Maiden Name Katie Tate

15. Birthplace N.C.

16 (a) Informant Mrs Jessie Hughes.

(b) Address 1302 Lawrence St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 3/19/1944 (month) (day) (year)

(c) Cemetery or crematory

Location Gastonia - N. Carolina

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St.

19 (a) MAR 20 1944 (Date rec'd by registrar) (b) Huntington Hilliard Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1944 to 3-17 1944, and that I last saw her alive on 3-17 1944.

Immediate cause of death Respiratory failure — Duration

Due to Pneumococcic meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. V. Latimis, Jr

Address Univ. Hosp. M. D.

Date signed 3-17-44

G 25240

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 4.6 H Registered No. G 25240

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 7032 Belclare Rd (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Lloyd Kniley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mabel J. Kniley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/26/1891

8. AGE: Years 52 Months 5 Days 23 If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Loftsman

11. Industry or business

FATHER 12. Name John Kniley

13. Birthplace Steelton Pa.

MOTHER 14. Maiden name Minnie Peters (?)

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/19/44 (month) (day) (year)

(c) Cemetery or crematory Rolling Green Location Pa.

18 (a) Funeral director John G. Main

(b) Address 3000 E. Balto St.

MAR 20 1944 (Date rec'd by registrar) (b) Huntingdon Pa. Williamsport Pa.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1944 at 12:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1944 to 3-19 1944 and that I last saw h/m alive on 3-19 1944

Immediate cause of death Generalized Lymphosarcoma

Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R. MacDonald M. D.

Address 1213 Light St Date signed 3-19-44

(over)

15241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G 15241

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Mura st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin M. Bush

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 213-10-0017

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude N. Bush

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5th 1889

8. AGE: Years 55 | Months 2 | Days 12 | If less than one day: hr min.

9. Birthplace: Balto, Md. (Town, county, and state)

10. Usual Occupation: Inspector

11. Industry or business: Balto. Transit Co.

FATHER
12. Name: John Bush
13. Birthplace: Md.

MOTHER
14. Maiden Name: Josephine Miller
15. Birthplace: Md

16 (a) Informant: Maude M. Bush
(b) Address: 2712 Mura st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's
Location: Hamsden

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st.

19 (a) MAR 20 1944 (Date received by registrar) (b) Signature of registrar: Florence Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17 1944, at 1:10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-10 1944 to 3-17 1944, and that I last saw h[illegible] alive on Mar 17 1944.

Immediate cause of death: Gastric hemorrhage — Duration

Due to: Peptic ulcer

Due to:

Other Conditions: Bilateral INGUINAL inguinal hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Thomas Brennan M. D.
Address: St Joseph Hospital Date signed 3-12 44

15242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 15242
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3212 Westwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie S. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband: ~~Father~~ John F. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14th 1871

8. AGE: Years 72 | Months 7 | Days 3 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name George Schellstede
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Harms
15. Birthplace Germany

16 (a) Informant Marguerite Miller
(b) Address 3212 Westwood Ave

17 (a) Burial (b) Date thereof 3/20/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Schwartz
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 20 1944 (b) Huntington Pittsburgh Md
(Date rec'd by registrar) Subdistrict

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17th 1944, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 15 19 44 to Mch 17 19 44 and that I last saw h[illegible] alive on Mch 16 19 44.

Immediate cause of death: Chronic cardio vas. disease — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest A. Kahn

Address 1736 Pop. Dr. Date signed 3/15/44

15243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G 15243

Registered No. P.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4101 Woodlea Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4101 Woodlea Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Janie A. Purnell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Wesley W. Purnell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1854

8. AGE: Years	Months	Days	If less than one day
89	5	18	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name David A. Anderson

13. Birthplace Md

MOTHER

14. Maiden Name Margaret T. (Unknown)

15. Birthplace Md.

16 (a) Informant Mrs Sindey

(b) Address 410 Woodlea Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3-04-44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Olivet

Location Balto. Md.

18 (a) Funeral director William Cook - UC

(b) Address 12 E. St. Paul St

19 (a) MAR 20 1944 (Date rec'd by registrar) Clinton Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17th 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to March 1944, and that I last saw h~~er~~ alive on 3-17 1944.

Immediate cause of death Myocardial Insufficiency — Duration 3 days

Due to Arteriosclerosis — 15 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Arthur J Davis M. D.

Address 800 N 32nd St Date signed 3-18-44

G 15244
10 #85476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 15244
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3487 Childs Ct. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert John Perlett

3 (b) If veteran, name war

3 (c) Social Security Account No. 192-03-8036

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 19, 1920

8. AGE: Years	Months	Days	If less than one day
23	10	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Pike Fitter
11. Industry or business Md Drydocks

FATHER
12. Name George Perlett (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Viola Colwell
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul st.

19 (c) Huntington Williams, Jr.
(Date rec'd by registrar) Registrar

MAR 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1944, at 1:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1943 to 3-18 1944, and that I last saw him alive on 3-18 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration 5 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mettman M. D.
Address B.C.H. Date signed 3-18-44

C 15245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. C 15245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3957 Wilsby Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 3957 Wilsby Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA CATHERINE NICHOLS

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. R. Nichols, Jr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1897

8. AGE: Years	Months	Days	If less than one day
46	10	20	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Howard F. Myers

13. Birthplace Carroll Co., Md.

MOTHER

14. Maiden Name Mary Powell

15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. Wm. R. Nichols, Jr.

(b) Address 3957 Wilsby Ave. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) [illegible] (b) Huntington Williams M.D.

MAR 20 1944

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 18, 1944 at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1943 to March 18 1944 and that I last saw h alive on 3/17, 1944.

Immediate cause of death Myocardial Insufficiency

Due to Circular Fibrillation

Due to Myocarditis

Due to Hypertension

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 D 4 hrs
6 mos
4 Years
4 years ?
4 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas F. Allitt M. D.

Address 532-E 22nd St. Date signed 3/18/44

G 15246

BALTIMORE CITY HEALTH DEPARTMENT X V G 15246

CERTIFICATE OF DEATH 44B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 & Calvert Sts
(c) Hospital or institution Union Memorial Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(b) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(c) Street No. 8202 Bonair Road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3(a) FULL NAME ELIZABETH F. THOMPSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Charles L. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 14 Dec. 1910

8. AGE: Years	Months	Days	If less than one day hr.	min
33	3	3		

9. Birthplace Maryland
(town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel D. Langlotz
13. Birthplace Maryland (Balto.)

MOTHER
14. Maiden Name Theresa McDonald
15. Birthplace Maryland (Balto.)

16 (a) Informant Husband
(b) Address 8202 Bonair Rd. Parkville, Maryland

17 (a) Burial (b) Date thereof 3 / 21 / 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Govans, Balto., Md.

18 (a) Funeral director Wm. J. Tiefener
(b) Address Balto, Md.

MAR 20 1944 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 March 1944, at 3 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 March 1944 to 17 March 1944 and that I last saw h alive on 17 March 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Bronchopneumonia	
Due to Hodgkin's Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hydrothorax, bilateral; Hydroperitoneum; Generalized lymphadenopathy

22. If death was due to external causes (fill in):
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J. Van Dell III M. D.
Address Union Memorial Hosp Date signed 3-17-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

G 15247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 F

Registered No. G 15247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VICTORIA McDONNELL

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Marcy R., Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1864

8. AGE: Years 79 | Months 6 | Days 24 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. G. March
13. Birthplace Md.

MOTHER
14. Maiden Name -- McLaughlin
15. Birthplace Md.

16 (a) Informant Mr. Marcy R. McDonnell, Jr.
(b) Address 3101 Glenmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 20 1944 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Mar. 18, 1944, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 - 1944, to Mar 18 1944, and that I last saw h alive on Mar 17 - 1944.

Immediate cause of death: Carcinoma of gall bladder — Duration: indef.

Due to

Due to

Other Conditions Chr. myocarditis — 5 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. J. Kellam, M. D.
Address 222 W. Monument St. Date signed 3/20/44

G 15248 West G. 15248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT FOLD OR USE CLIPS ON THIS CERTIFICATE. IT IS PREPARED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. Shiplet's Trailer Camp 2341 Monumental Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerry West

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1	131	14	hr. min

9. Birthplace Laurel, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Donald M. West
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Ora Smith
15. Birthplace N. Carolina

16 (a) Informant Mr. Donald M. West
(b) Address 2341 Monumental Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Catto, Md.

18 (a) Funeral director Chas. J. Pickens Home
(b) Address Catto, Md.

19 MAR 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17 1944, to Mar 18 1944, and that I last saw h/im alive on Mar. 18 1944.

	Duration
Immediate cause of death Lobar pneumonia	3 days
Due to Measles	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Arthur Rosebrock, M.D.
Address St. Agnes Hosp. Date signed 3/18/44

G 15249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G 15249

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 Ellerslie Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Ellerslie Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS M. MYERS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	216-10-5521	Male	White	Married

6 (b) Name of husband or wife Edith V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1880

8. AGE: Years	Months	Days	If less than one day
63	8	19	hr. min.

9. Birthplace Ashland, Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Leimbach & Williams

FATHER
12. Name Charles Myers
13. Birthplace Md.

MOTHER
14. Maiden Name Louise --
15. Birthplace unknown

16 (a) Informant Mrs. Edith V. Myers
(b) Address 3009 Ellerslie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory Chestnut Ridge Cem.
Location Balto. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 20 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 17, 1944, at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Mar. 17 1944, and that I last saw [illegible] alive on Mar. 7 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 hour

Due to Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Granger M. D.
Address 1402 E. Lanvale Date signed 3-18-44

15250 HEALTH DEPARTMENT—CITY OF BALTIMORE 15250

CERTIFICATE OF DEATH

93D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2446 Fleet St. St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da. 43

2. FULL NAME Louis Chylinski

If U. S. Veteran specify WAR

(a) Residence: No. 2446 Fleet St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Chylinski

6. DATE OF BIRTH (month, day, year) 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Carpenter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Poland

FATHER

13. NAME Frank Chylinski

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Emma Baraki

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT Helen Karwacki

(Address) 2446 Fleet St.

18. BURIAL, CREMATION, OR REMOVAL

Place Rosary Date March 23 19 44

19. UNDERTAKER Fred W Ozarzuski

(Address) 1930 Eastern Ave

20. FILED MAR 20 1944 19 Huntington Hitt Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 19, 1944

22. I HEREBY CERTIFY, That I attended deceased from March 3, 1944 to March 19, 1944

I last saw him alive on 3-18, 1944. Death is said to have occurred on the date stated above, at 11 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertensive Cardiovascular Disease	1943
Other contributory causes of importance: Arteriosclerosis	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Lee B Gallagher M. D.

(Address) 101 W Monument St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

15251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 15251

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 434 N. Pulaski St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 434 N. Pulaski St

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Lena Berger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife David —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lyman Berger

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Fagie —

MOTHER 15. Birthplace Russia

16 (a) Informant Mrs. Morganstein

(b) Address 434 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)

(c) Cemetery or crematory Baredale

Location .....

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto St

(c) Huntington Williams, Mgr

MAR 20 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-44 19.. at 2.57 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1944 to 3/19 1944.

and that I last saw h[illegible] alive on 3/19 1944.

Immediate cause of death Bronchopneumonia — Duration 1 day

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Benjamin Miller M.D.

Address 20 30 Wilkens ave. Date signed 3/20/44

15252

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G 15252
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 Division St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 17 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Division St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Kearney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			13 hrs min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Lewis Kearney
13. Birthplace Vaughn N.C.

MOTHER
14. Maiden Name Eunice Harris
15. Birthplace Vaughn N.C.

16 (a) Informant Eunice Kearney
(b) Address 1304 Division St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS HOSPITAL MAR 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) MAR 20 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944, at 4.44 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1944 to March 17 1944, and that I last saw h alive on 3-14- 1944.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. L. Peacock

Address 463 Cathedral Date signed 3-22-44 M. D.

VS 3

F 0792

G 15253

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 15253

159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Daniels (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Landacre
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/44

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Richard Landacre
13. Birthplace W. Va.

MOTHER 14. Maiden Name Dantie Stewart
15. Birthplace W. Va.

16 (a) Informant Dantie Landacre
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 20 1944 (Signature of Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 10 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1944 to 3-10 1944, and that I last saw him alive on 3-10 1944

Immediate cause of death
Eclampsia

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. M. Emery Jr. M. D.
Address Univ. Hosp. Date signed 3-17-44

VS 150

0794

G 15254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G 15254 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BLANK RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution:
W. B. G. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Oakford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BABY STEINER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			14 hr. min

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 20 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16/44 19 to 3/17 19 44, and that I last saw h 17 alive on 3/17 19 44

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions Hare-lip; Cleft Palate; Club-foot-bilateral

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. M. Friedman M. D.
Address W B G H Date signed 3/17/44

VS 150

0793

25255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered C 25255

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 S. Gilmour St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 S. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

1944

3 (a) FULL NAME Alice E. McManus

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Thomas McManus
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1876

8. AGE: Years	Months	Days	If less than one day
67	4	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John Yoe
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary A. ?
15. Birthplace Baltimore, Md.

16 (a) Informant Thomas McManus
(b) Address 420 S. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore County

18 (a) Funeral director Frederick C. Cole
(b) Address 1200 W. Lombard St.

19 (a) Date received by Local Registrar MAR 20 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16th 1944, at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1944, to March 16 1944, and that I last saw h alive on March 16 1944.

Immediate cause of death: Carcinoma of Intestines — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scognetti
Address 1729 W Lombard St Date signed 3-16-44 M. D.

G 15256
#86804
30

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940

G 15256
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 610 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Charles Ruff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife: Mary (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1869

8. AGE: Years	Months	Days	If less than one day
74	8	1	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Government Pension
11. Industry or business

FATHER
12. Name: Charles Jacob Ruff (d)
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Jane Barnes (d)
15. Birthplace: Md.

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)
(c) Cemetery or crematory: M.F. Zion Cem
Location: Mountain Maryland Co. Md.

18 (a) Funeral director: Wm Francis A. Hanraty
(b) Address: 578 W. Biddle St.

19 (a) (Signature) (b) Huntington Williams, M.D.

MAR 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1944, at 2:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1944 to 3-16 1944 and that I last saw him alive on 3-15 1944.

Immediate cause of death	Duration
Bronchopneumonia	24 hrs
Due to Diverging in eyes	11 days
Due to Probably goiter & fatigue	11 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 4-78
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Baltimore City Hosp. Date signed Mar 13 1944

G 15257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 178a

G 15257
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Etting Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeremiah Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Cora

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) April 16, 1865

8. AGE: Years 78 | Months 11 | Days — | If less than one day hr. min.

9. Birthplace Unknown (Town, county and state)

10. Usual Occupation Butler

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Charles L. Bryant
(b) Address Rear 4" of Dix & of Hampton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21 (month) (day) 1944 (year)
(c) Cemetery or crematory Pikesville Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 2651 Druid Hill Ave

19 Rec'd MAR 20 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16- 1944, at 11:30 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury 3-16-44 at 17:2 P. M.
(b) Where did injury occur? 1307 Etting Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Carburetor rubber hose leaked

23. Signature Howard J. Worden M.D.
Medical Examiner.
Date signed 3-17-44

15258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G 15258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Etting Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Etting Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora Hicks

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jeremiah

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1886

8. AGE: Years 57 | Months 7 | Days 7 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Isaac Bryant
13. Birthplace Virginia

MOTHER 14. Maiden Name Martha Wallace
15. Birthplace Virginia

16 (a) Informant Charles L. Bryant
(b) Address Route 1 Box 308 Hampton Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Hullan
(b) Address 1631 Druid Hill Ave.

19 (a) MAR 20 1944 (Date rec'd by registrar) Huntington Williams U.S. Registrar

VR 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16- 1944, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-16-44 at 12 P. M.
(b) Where did injury occur? 1307 Etting Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas heater rubber hose leaked

23. Signature Howard Silverman M.D. Medical Examiner.
Date signed 3-17-44

5259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 15259
Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Rutland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rhoda Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1892

8. AGE: Years	Months	Days	If less than one day
51	9	-	hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jerry Wright
13. Birthplace N. C.

MOTHER
14. Maiden Name Anne Wright
15. Birthplace N. C.

16 (a) Informant Thomas Harris
(b) Address 914 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mrs. P. G. Elliott & Dtr.
(b) Address 1129 N. Carolina St.

19 MAR 20 1944 Registrar's Office Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 16 - 1944 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 10 - 1944 to 3 - 11 - 1944, and that I last saw her alive on 19.

Immediate cause of death: Cardio - Renal Disease — Duration: Unknown

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. P. Conzier M. D.
Address 611 - N. Carolina Date signed 3-18-44

VS 150

G 15260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

Registered No. G 15260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Baltimore City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) D O A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 Parrish St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Joseph Butler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Frances Butler
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Butler
13. Birthplace Md.

MOTHER
14. Maiden Name Georgianna Johnson
15. Birthplace Md.

16 (a) Informant Frances Butler
(b) Address 1137 N. Parrish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo H Kelly
(b) Address 1303 Pressman St

MAR 20 1944 (Date received by Registrar) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 11:50 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

Signature Robert L. Graham M.D.
Medical Examiner
Date signed March 18, 1944

G 15261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G 15261 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State U.S. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Maker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugenia Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1872

8. AGE: Years 71 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name Isaac Roberts

13. Birthplace Va.

MOTHER 14. Maiden Name Jennie

15. Birthplace Va.

16 (a) Informant Jennie Butler (Niece)

(b) Address 1625 Maker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto. Co. Md.

18 (a) Funeral director Charles S. Cooper

(b) Address 512 N. Carrollton Ave

19 MAR 20 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1944, at 8:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Crushing of chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3/15/44 at 8 P. M.

(b) Where did injury occur? Mt. Royal Terrace & Harrington Avenue

(c) Did injury occur at home, on farm, industrial place, in public place? Public, While at work? No.

(d) Means of injury Pedestrian struck by auto.

23. Signature Henry L. Wollenweber, M.D. Medical Examiner.

Date signed March 16, 1944

For H. L. Wollenweber, by Howard J. Weddell, M.D.

C 15262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. C 15262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1146 Shields alley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1146 Shields alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harvey James H. Banks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Baltymore Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Walter Banks

13. Birthplace Md.

MOTHER 14. Maiden Name Alene Snead

15. Birthplace Md.

16 (a) Informant Lillian Williams

(b) Address 1146 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

MAR 20 1944 (Date received) (b) Thomas J. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944 at 11 15 AM

21. I certify that I took charge of the remains described above, held an Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.

Date signed

VS 151

G 15263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G 15263 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Green Sts
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 W. Mulberry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Coates or James

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years abt 58 | Months | Days | If less than one day hr. min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual Occupation Cooking

11. Industry or business

FATHER 12. Name

13. Birthplace Md

MOTHER 14. Maiden Name

15. Birthplace Md

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/1944 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

MAR 20 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13-1944, at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11-1944, to 3-13-1944, and that I last saw h/ M alive on 3-13 1944.

Immediate cause of death Uremia — Duration

Due to Benign Prostatic Hypertrophy Hypertrophy

Due to Pyelonephritis

Other Conditions Dilated bladder & diverticula

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Range M. D.

Address Lombard + Green Sts. Date signed 3-17-44

15264

AB-86832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15264

Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 N. Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Hill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Amy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6-1903

8. AGE: Years	Months	Days	If less than one day
41	-	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Columbia Hill (D)
13. Birthplace Md.
14. Maiden Name Sarah Milton
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

MAR 20 1944 Thomas Tom Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1944, at 8:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1944, to 3-18 1944, and that I last saw h in alive on 3-18 1944.

Immediate cause of death: Pneumonia — Duration: 2 weeks

Due to

Due to over

Other Conditions Lung Abscess ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Do above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul McKenna M. D.
Address B-Co Date signed 3/19/44

G 15265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15265 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division

(c) Hospital or institution: Provident Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 14 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore Md

(c) City or town (If outside city or town limits, write RURAL and give town) Baltimore Md

(d) Street No. 913 Madison Ave (If rural, give location)

(e) Citizen of foreign country? (Yes or No) Yes

If yes, name country

3 (a) **FULL NAME** Dorothy Bibens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1929

8. AGE: Years 14 Months 15 Days If less than one day hr min

9. Birthplace Cape Charles, Va. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

MOTHER / FATHER

12. Name Nat Bibens

13. Birthplace Cape Charles, Va.

MOTHER

14. Maiden Name Beatrice Mapp

15. Birthplace Cape Charles Va.

16 (a) Informant John Mapp

(b) Address 913 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month, day, year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 MAR 20 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1944, at 5-35 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 2-10- 1944, to 3-16-1944, and that I last saw her alive on 3/16 1944

Immediate cause of death Pericecal Abscess — Duration

Due to Tuberculous Enteritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-15-44

Major findings of operation: Pericecal abscess & TBC of Peritoneum

nf autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. B. Higgins

Address Provident Hosp Date signed 4/14/44

PHYSICIAN

I subscribe the cause to which death should be charged statistically

G 15266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

Registered No. G 15266

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT FOLD FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 S. Durham St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S. Durham St
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Daniel P. Doose Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/29

8. AGE: Years	Months	Days	If less than one day: hr	min
14	8	15		

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business School Boy.

FATHER
12. Name Daniel P. Doose Sr.
13. Birthplace Va

MOTHER
14. Maiden Name Ella Bruce
15. Birthplace Va

16 (a) Informant John M. Doose
(b) Address 417 Cummings Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (months, days, years)

(c) Cemetery or crematory
Location Sake, Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

MAR 20 1944
(Registered by Registrar)

(b) Huntington Thomas Funeral Home

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 18 1944 at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1944 to 3-18 1944, and that I last saw him alive on 3/15 1944

Immediate cause of death: Sarcoma of spine — Duration: 1 yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town, County, State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible]

Address 1500 E Madison St Date signed 3/18

G 15267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

G 15267 Registered No.

The accuracy of this information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write R.D. and give town)
(d) Street No. 1513 E Joycette Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmer W. Mabell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 1902

8. AGE: Years 41 | Months 11 | Days 13 | If less than one day: hr. min

9. Birthplace Churchton Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Mabell
13. Birthplace Calvert Co.

MOTHER
14. Maiden Name Rosie Boardley
15. Birthplace Calvert Co.

16 (a) Informant Morris Mabell
(b) Address Churchton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 22/44 (month, day, year)
(c) Cemetery or crematory Franklin - Location Churchton, Md

18 (a) Funeral director E. B. Johnson
(b) Address Annapolis, Md

19 (a) MAR 20 1944 (Date rec'd by registrar) (b) Harry C. Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 7:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner

Date signed March 16, 1944

450617

G 15268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15268
Registered No. 462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. yrs., mos., or days 17 D
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 797 George St (If rural give address)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race Black
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Jeremiah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-99
8. AGE: Years 44 Months 8 Days 13 If less than one day hr min
9. Birthplace Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

MOTHER | FATHER
12. Name James Johnson
13. Birthplace Md
14. Maiden Name Prude Johnson
15. Birthplace Md

16 (a) Informant Ricarda
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-44 (month) (day) (year)
(c) Cemetery or crematory Annapolis Md
Location Ama. Lindel Comty

18 (a) Funeral director William A Jackson
(b) Address 916 Penna. ave

19 (a) Date received MAR 20 1944 (b) Huntington Williams M.D. Registrar
8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17 19 44 M

21. I certify that death occurred on the date above stated, that I attended deceased from Mar 7 19 44 to Mar 17 19 44 and that I last saw h[illegible] alive on Mar 17 19 44

Immediate cause of death
Due to (a) Shock following
Due to (b) gastroenterostomy
Due to (c) for ca. of stomach

Duration
4 wks

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3-15-44
Major findings of operation: Ca. of stomach
of autopsy: none

PHYSICIAN
Underline the cause to which death should be attributed in case of violence

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Slaon M.D.
Address J. H. Date signed 3/19/44

G 15269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15269 Registered No.

The items on this certificate are important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 693 Linden Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Vaughn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1887

8. AGE: Years 57 | Months 56 | Days - | If less than one day: hr - min

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Contractor

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Chas. Tottmon

(b) Address 1228 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co Md

18 (a) Funeral director Isaiah L. Brown Inc

(b) Address 108 W Montgomery St

19 (a) MAR 20 1944 (Date rec'd by registrar) for Hattie Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1944 at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.

Date signed March 15, 1944.

VS 151

G 15270

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 82a

G 15270 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town York (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Center Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Schreecengost
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Wm Schreecengost
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 6 - 1901

8. AGE: Years	Months	Days	If less than one day
43	1	14	hr min

9. Birthplace York Pa (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Common Fair
13. Birthplace York Pa

MOTHER
14. Maiden Name Emma Stoner
15. Birthplace York Pa

16 (a) Informant Wm. Wm Schreecengost
(b) Address 125 Center St York Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 22/24 (month) (day) (year)
(c) Cemetery or crematory Mt. Rose Cem
Location York Pa

18 (a) Funeral director Wm J. Fechnet & Sons
(b) Address North Penn Square

19 (a) MAR 20 19 24 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 20 - 19XX, at 8 55 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner
Date signed 3 - 20 - XX

Please write plainly. The information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

15271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a G 15271

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 635 Lombaston Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days 9 mo

(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 635 Lombaston Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine M. Vickers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed~~ or ~~divorced~~ Married

6 (b) Name of husband ~~or wife~~ Wm P

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1898

8. AGE: Years 46 | Months 1 | Days 4 | If less than one day hr min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name Peter Thukelbach

13. Birthplace Germany

MOTHER 14. Maiden Name Dorothy Ullrich

15. Birthplace Germany

16 (a) Informant Wm P Vickers

(b) Address 635 Lombaston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd.

18 (a) Funeral director John J. McGann

(b) Address 3600 E. Baltimore St

19 (a) Date received by Registrar MAR 20 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6 1943 to 3/13 1944, and that I last saw her alive on 3/13 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to: Arterial Sclerosis, Chronic Nephritis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas. A. Goodbody M.D.

Address 7923 W Park Ave Date signed 3/15/44

PHYSICIAN

I underline the cause to which death should be charged statistically

Houghtlings

15272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 170V

Registered No. C 15272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (Curtis Bay) (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1511 Sycamore St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leland J. Houghtling

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-0744

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillie V

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 28 1908

8. AGE: Years: 35 | Months: 7 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: General Refractories Co

FATHER
12. Name: Leland Houghtling
13. Birthplace: N.Y.

MOTHER
14. Maiden Name: Anna B Zeller
15. Birthplace: Md

16 (a) Informant: Mrs Lillie V Houghtling
(b) Address: 1511 Sycamore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 22/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Cedar Hill
Location: Brooklyn Md

18 (a) Funeral director: William M Marech
(b) Address: 715 Light St Baltimore, Md.

19 (a) Date received by Registrar: MAR 20 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 7: A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: March 18, 1944 6:45 A M.
(b) Where did injury occur? Potapsco Ave & 7th St
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury: Motorcycle turned over

23. Signature: Robert Lee Graham M.D. Medical Examiner

Date signed: March 18, 1944

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15273

G 15273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4512 Furley Avenue (If rural give R.F.D. or location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Baby Propili
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: infant
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 1 day | Months | Days: 2 | If less than one day: hr | min

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER: 12. Name Dante D. Propili
13. Birthplace Italy

MOTHER: 14. Maiden Name Rose B. Bellini
15. Birthplace Providence R.I.

16 (a) Informant Mrs. Dante D. Propili
(b) Address 4512 Furley ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard D. Kuck
(b) Address 5305 Harford Road

19 (a) (b) Registrar

MAR 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1944, at 1-30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/11 1944, to 3/18 1944, and that I last saw h[illegible] alive on 3/18 1944

Immediate cause of death Bronchopneumonia — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert E Chard M.D.
Address St Joseph Hosp. Date signed 3/18/44

G 15274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15274 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5407 Catalpha Rd.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME HERBERT FLOYD CLOUGH

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-10-3553

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1891

8. AGE: Years	Months	Days	If less than one day
52	9	14	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Beth. Fairfield

FATHER 12. Name Floyd Clough
FATHER 13. Birthplace

MOTHER 14. Maiden Name Fallon
MOTHER 15. Birthplace

16 (a) Informant Frances Clough
(b) Address Wife

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5303 Harford Rd.

19 (a) MAR 20 1944 (b) [illegible] Registrar
Date rec'd by registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1944 at 3:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1944 to 3/19 1944 and that I last saw h[illegible] alive on 3/17 1944.

Immediate cause of death Hypertension C. V. D. Cerebral hemorrhage

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard J. Rusk M. D.
Address 5303 Harford Rd. Date signed 3/19/44

G 15275

AB-86970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15275 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1518 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry George Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Olive

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 (1877) 1867

8. AGE: Years	Months	Days	If less than one day
(66) 76	8	20	hr min

9. Birthplace England (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location north gate + Box 44

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 Broadway

MAR 20 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1944 at 2:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1944 to 3-18 1944 and that I last saw h alive on 3-18 1944

Immediate cause of death: Cellulitis Rt Leg
Osteomyelitis Rt Leg
Due to
Due to Traumatic Injury / Dehydration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Cellulitis 2 yrs ? Burn?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald Bozell M.D.
Address Balto City Hosp Date signed 3/18/44

15276

15276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 84 D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Howard

(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)

(d) Street No. Old Fred Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Audrey E. Rawls

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-25-27

8. AGE: Years	Months	Days	If less than one day
16	5	24	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Joseph V Rawls

13. Birthplace N.C.

MOTHER 14. Maiden Name Billie D Cantwell

15. Birthplace Tenn

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-44 (month) (day) (year)

(c) Cemetery or crematory St Johns Cem

Location Ellicott City Md

18 (a) Funeral director F. C. Negenbottom

(b) Address Ellicott City Md

19 (a) (b)

(Date received by local registrar) Registrar

MAR 20 1944

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 19 1944, at 8 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 14 1944 to MAR 19 1944, and that I last saw her alive on MAR 19 1944.

Immediate cause of death: Anorexia nervosa — Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert E. Farber M. D.

Address Johns Hopkins Hosp. Date signed 3/20/44

G 15277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15277 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2604 N. Calvert street

(c) Hospital or institution: -----

(d) Length of stay in hospital or inst. (yrs., mos., or days) --

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County --

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2604 N. Calvert street (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MARY THERESE HYSON

3 (b) If veteran, name war ----

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Widowed

6 (b) Name of husband or wife Thomas A. Hyson

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1871

8. AGE: Years	Months	Days	If less than one day
72	6	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Robert S. Weaver

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Laura T. Tuttle

15. Birthplace Balto. Md.

16 (a) Informant Mrs. M. Leo Morgan

(b) Address 2602 N. Calvert street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location Freeland, Maryland

18 (a) Funeral director Chas. J. Evans & Son

(b) Address 118 N. Mt. Royal Ave

19 (a) (Signature of registrar) (b) Registrar

MAR 20 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17, 1944. to Mar. 17, 1944, and that I last saw her alive on Mar. 17, 1944.

Immediate cause of death	Duration
Acute Cardiac Failure	unknown
Due to Chronic myocarditis	?
Due to ✓	
Other Conditions ✓	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: ✓

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ✓

(b) Date of occurrence ✓ at ✓ M

(c) Where did injury occur? ✓ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)

(e) Means of injury ✓

23. Signature Frank H. Ogden M. D.

Address 2701 N. Calvert Date signed Mar 18, 1944

G 15278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 15278
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 7 3
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 159 West Cross Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "A" Doughty Twin #1

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1944

8. AGE: Years	Months	Days	If less than one day
			22 hr. 46 min

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Doughty
13. Birthplace South Carolina

MOTHER
14. Maiden Name Eva McFadden
15. Birthplace South Carolina

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 20 1944
18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 20 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1944, to March 12 1944, and that I last saw him alive on March 12 1944.

Immediate cause of death Prematurity — Duration

Due to Maternal Hydramnios

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip A. Stephan, Jr. M. D.
Address Johns Hopkins Hosp. Date signed 3/17/44

VS 150

10.97

G 15279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G 15279

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 23/1

(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 159 West Cross Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3 (a) FULL NAME Baby "B" Doughty Twin #2

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 11, 1944

8. AGE: Years ..... Months ..... Days ..... If less than one day 2 hr 59 min

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name William Doughty

13. Birthplace South Carolina

MOTHER

14. Maiden Name Eva McFadden

15. Birthplace South Carolina

16 (a) Informant Hospital records

(b) Address Johns Hopkins Hospital

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory .....

Location .....

JOHN HOPKINS MEDICAL SCHOOL MAR 2 1944

18 (a) Funeral director Commissioner of Health

(b) Address .....

19 MAR 20 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1944 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1944, to March 11 1944, and that I last saw him alive on March 11 1944.

Immediate cause of death Prematurity

Due to Maternal Hydramnios

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury .....

23. Signature Philip P. Stephens, Jr. M.D.

Address Johns Hopkins Hospital Date signed 3/17/44

0795

G 15280

BALTIMORE CITY HEALTH DEPARTMENT X 159

CERTIFICATE OF DEATH

G 15280 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Lombardy Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-29-44

8. AGE: Years	Months	Days	If less than one day
		15	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation @ Rest
11. Industry or business

FATHER
12. Name Andy Brooks
13. Birthplace Va.

MOTHER
14. Maiden Name Nina Corbett
15. Birthplace W. Va.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 20 1944

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D.

19 (Date rec'd by registrar) MAR 20 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 15 1944 at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1944 to Mar 15 1944 and that I last saw him alive on Mar 15 1944.

Immediate cause of death Resp. failure — Duration

Due to Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp Date signed 3-16-44

VS 150

10.96

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G 15281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 15281 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 N. Chester St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHESTER CZESLAW. KOLUCH

3 (b) If veteran, name war

3 (c) Social Security Account No. 213 07 7294

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Mary Koluch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1944

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Moulder
11. Industry or business

FATHER
12. Name Joseph Koluch
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant Mary Koluch
(b) Address 13 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave

19 (a) (Signature of registrar) (b) Registrar

MAR 20 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to March 17 1944 and that I last saw h— alive on March 17 1944

Immediate cause of death: Coronary Thrombosis
Due to Cardiac Failure
Due to Subdural Hemorrhage
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 3579 Eastern Ave Date signed March 20 1944

G 15282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G 15282

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 Gwynn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred S. Righter

3 (b) If veteran, name war None
3 (c) Social Security Account No. 218-09-3396

4. Sex M
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Myrtle N. Righter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31-1919

8. AGE: Years 24 25 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Davidson Transportation

FATHER
12. Name Richard M. Righter
13. Birthplace —

MOTHER
14. Maiden Name Rena —
15. Birthplace —

16 (a) Informant Myrtle N. Righter
(b) Address 319 Gwynn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director Roll & B.M. Walters
(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MAR 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944 at 1 1/2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1944 to March 17, 1944, and that I last saw him alive on 3/17/1944.

Immediate cause of death Congesting Heart failure — Duration

Due to Rheumatic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Murray Holmes M. D.
Address Sinai Hosp Date signed 3/18/44

G 15283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15283 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1660 E 25th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1660 E 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. House

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-3252

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barbra C. House
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20th 1885

8. AGE: Years	Months	Days	If less than one day
58 59	10	27	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Paymaster
11. Industry or business Surg Office

FATHER
12. Name Thomas J. House
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Burr
15. Birthplace Md

16 (a) Informant Barbra C House
(b) Address 1660 E 25th St.

17 (a) Burial (b) Date thereof 3-21st 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo B. Cook
(b) Address 1204 N. Patterson Park Avenue, Baltimore, Md.

19 (a) MAR 20 1944 (b)
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17th 1944, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20-1940 to 3-17-1944 and that I last saw b alive on Feb - 1944

Immediate cause of death	Duration
Probable coronary occlusion	Sudden
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Leo B. Lybert M. D.
Address 902 Harford Rd Date signed 3-20-44

Approved: Robert Lee Graham M.D. 3/20/44

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58D

G 15284 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Preston & Rose Sts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Dorothea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Nun

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Sister Teacher

11. Industry or business Mt Bethany School

FATHER
12. Name James A McGuire
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Murray
15. Birthplace Ireland

16 (a) Informant James A Murray
(b) Address Wilmington Del

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Cook
Address 101-03 N. Patterson Park ave

MAR 20 1944

19 (a) (Date rec'd by registrar) (b) Registrar

Registrar for Wilmington, Del.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1944 to March 18 1944 and that I last saw her alive on March 18 1944.

Immediate cause of death Acute Heart Failure

Due to Acute rheumatic carditis

Due to Rheumatic fever

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan, M.D.

Address St Joseph's Hospital Date signed 3-18-44

G 15285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82B

G 15285 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2417 Crest Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Crest Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA A. TRADER

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Thomas H. Trader
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1853

8. AGE: Years	Months	Days	If less than one day
90	9	21	hr. min.

9. Birthplace Easton, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name unknown Seegar
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. George Clark Godman
(b) Address 2417 Crest Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 20 1944 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Mar. 18, 1944, at 8:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to 3-18 1944 and that I last saw her alive on 3-17 1944.

Immediate cause of death Cerebral Thrombosis
Due to Right Hemiplegia
Due to Arterial sclerosis
Due to Senility

Duration 8 days / yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Adelhurst M. D.
Address Loth Park. Hyles Date signed 3-20-44

A G-15286 — XG-15286

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 80B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Binghampton, N.Y. (If outside city or town limits, write RURAL and give town)
(d) Street No. 62 Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Lobevero

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-42

8. AGE: Years	Months	Days	If less than one day
1	5	29	hr. min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Dick Lobevero
13. Birthplace N.Y.
MOTHER — 14. Maiden Name Eleanor Piloicciotti
15. Birthplace N.Y.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)
(c) Cemetery or crematory
Location Binghampton, N.Y.

18 (a) Funeral director William J. Dickner & Sons
(b) Address North & Pa

19 (a) (Date received by registrar) (b) Registrar

MAR 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944 at 4:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1944 to Mar 19 1944 and that I last saw her alive on Mar 19 1944

Immediate cause of death — Duration
Respiratory failure
Due to Schilder's Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M. D.
Address Johns Hopkins Hosp. Date signed 3-20-44

G 15287

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 74a

G 15287 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Woodford Rd (If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country England

3 (a) FULL NAME Joseph Francis Coffay
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Mary K. O'Donnell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1876

8. AGE: Years	Months	Days	If less than one day
67	11	29	11 hr. 20 min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business

MOTHER / FATHER
12. Name Timothy Coffay
13. Birthplace Ireland
14. Maiden Name Mary Tierney
15. Birthplace Ireland.

16 (a) Informant Miss Eileen J. Coffay
(b) Address 405 Woodford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) MAR 20 1944 (Date rec'd by registrar) (b) Huntington Hilldrup, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944 at 11 29 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 29 1944, to March 18 1944, and that I last saw h/M alive on March 18, 1944

Immediate cause of death
Pneumonia
Respiratory failure
Due to Pneumonia

Duration
4 days
3 hrs.
4 days

Due to

Other Conditions Uremia / Lymphosarcoma (Leukemia, Chronic)
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy Pneumonia, Pneumonia, enlarged spleen & liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Berry M. D.
Address Mercy Hospital Date signed 3/18/44

G 15288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 15288

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1432 John St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1432 John St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Leila Risteau Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles H. Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 23, 1862

8. AGE: Years	Months	Days	If less than one day
81	11	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name George K. Walter

13. Birthplace Baltimore

MOTHER

14. Maiden Name Susan Risteau

15. Birthplace Baltimore

16 (a) Informant Mr. George E. Dorsey

(b) Address 1432 John St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 21, 1944 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore, Md.

18 (a) Funeral director H. W. Meadows

(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19 1944, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to 3/19 1944, and that I last saw her alive on 3/18/44

Immediate cause of death Myocardial Arterio-Sclerosis

Duration Several

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. T. Moody

Address 1403 Packard Date signed 3/20/44

Huntington Williams, M.D.

G 15289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1144 D

G 15289

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Linden Ave Madison
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 20 d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5701 Greenleaf Road
(If rural give location)
(e) Citizen of foreign country? —No— (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Albert Schleunes Sr.

3 (b) If veteran, name war: yes-W.W.1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dorothy F. Schleunes
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Dec-8-1894

8. AGE: Years 49 | Months 3 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore-Md (Town, county, and state)

10. Usual Occupation Pres't American Coal-
11. Industry or business Pad Company.

FATHER
12. Name George Schleunes
13. Birthplace Balti Md.

MOTHER
14. Maiden Name Beatrice Albert-
15. Birthplace Balto Md

16 (a) Informant Mrs Dorothy F. Schleunes
(b) Address 5701 Greenleaf Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart & Mason Company
(b) Address 18 W Lanvale St Baltimore Md

19 (a) [illegible] (b) [illegible] Registrar

MAR 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1944 at 247 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1944 to 3-19 1944. and that I last saw him alive on 3-19 1944.

Immediate cause of death: Multiple Brain abscess

Due to: Lung abscess, rt.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-18-44

Major findings of operation: Lung abscess

of autopsy: above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Young Jr. M. D.
Address Md. General Hosp Date signed 3-19-44

G 15290

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 94a

G 15290

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-7-15
(e) Length of stay in Baltimore (yrs., mos., or days) 14-7-15

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Jersey (b) County
(c) City or town Newark (If outside city or town limits, write RURAL and give town)
(d) Street No. 31 Mulberry street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. James P. Hanley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1870

8. AGE: Years	Months	Days	If less than one day
73	6	28	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER
12. Name Patrick Hanley
13. Birthplace Ireland

MOTHER
14. Maiden Name Josephine Lee
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Stewart Mourn Co.
(b) Address 108 W. Mulberry Ave.

19 (a) MAR 20 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 5:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944, to March 18 1944, and that I last saw him alive on Mar. 18 1944.

Immediate cause of death Coronary Thrombosis — Duration 5 days

Due to

Due to Arteriosclerosis

Other Conditions Senile Dementia — 14 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James P. Hanley M. D.
Address 33 W. Mulberry Date signed

VS 8

G 15291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 15291 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6420 Reisterstown Road

(c) Hospital or institution: Mount Hope Retreat

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-1-4 16

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 16

(d) Street No. 608 Claremont Street (If rural give location)

(e) Citizen of foreign country? NA (Yes or No)

If yes, name country

3 (a) FULL NAME Mary A. Sandford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Concord, New Hampshire (Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business

FATHER

12. Name unknown

13. Birthplace unknown

MOTHER

14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant Mount Hope Retreat

(b) Address 6420 Reisterstown Road

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-20-44 (month) (day) (year)

(c) Cemetery or crematory St Mary's

Location Concord - N. H.

18 (a) Funeral director Edward Maguire Co

Address 108 W. Franklin

MAR 20 1944

19 (a) (Date rec'd by registrar) (b) Interring for Millington Md

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944 at 9.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1940 to Mar 20 1944, and that I last saw her alive on Mar 20 1944.

Immediate cause of death	Duration
R. Cerebral Hemorrhage	4 days.
Due to	
Due to Senile psychosis	
Other Conditions simple deterioration	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel P. Hayes M. D.

Address 33 W. Madison St. Baltimore Md. Undersigned

G 15292 17 G 15292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 779

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 835 Hamilton Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 835 Hamilton Terrace (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME HELEN BOLLING or SMITH

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Jessie H.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1 1911

8. AGE: Years	Months	Days	If less than one day
32	8	17	..... hr. ..... min.

9. Birthplace Philadelphia (Town, county, and state)

10. Usual Occupation Don't know

11. Industry or business

MOTHER FATHER

12. Name Frank M. Chambers

13. Birthplace Penna

14. Maiden Name Lottie Taylor

15. Birthplace Va

16 (a) Informant Lottie Taylor (Mother)

(b) Address 504 - 3rd St S.E. Wash D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24 1944 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Wash D.C.

Location Washington D.C.

18 (a) Funeral director W. W. Chambers

(b) Address Washington D.C.

19 (a) 3-16-44 (Date received by Registrar) (b) Livingston Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1944 at 5 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic alcoholism

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury .....

23. Signature H. L. Wallenmeyer M.D. (or Medical Examiner.)

Date signed 3-16-44

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

G 15293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

G 15293 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1839 W. Lombard st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-24
(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 W. Lombard st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carmela Liberto
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed
6 (b) Name of husband ~~or wife~~ Frank Liberto
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 21st 1874
8. AGE: Years 70 | Months 1 | Days 27 | If less than one day hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name (Unknown) Jacobia
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Giordina
15. Birthplace Italy

16 (a) Informant Samuel Liberto
(b) Address 839 W. Lombard st
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto, Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st
19 (a) MAR 21 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18th 1944, at 7:05 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to March 18 1944 and that I last saw him alive on March 18 1944.
Immediate cause of death
Chronic Myocarditis
Due to
Due to
Other Conditions Chronic Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Albert Scagnetti
Address 1724 W Lombard st Date signed 3-20 M. D.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

15294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15294 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2012 Mc Elderry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Mc Elderry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M Forsyth

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wilbur C. Cr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11 1868

8. AGE: Years 85 Months 5 Days 7 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Hoge
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Flannigan
15. Birthplace Md

16 (a) Informant Edgar M Forsyth
(b) Address 2012 Mc Elderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory St Louis
Location Baltimore Md

18 (a) Funeral director Wilbur Cr Lodge
(b) Address 1219 E Pratt St

19 MAR 21 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 5 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10 1944 to Mar 18 1944 and that I last saw her alive on Mar 18 1944.

Immediate cause of death Chronic Myocarditis — Duration

Due to Grippe

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. Signature Joseph Lawlor M.D.
Address 444 N. Edmondson Ave Date signed 3/20/44

G 15295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 15295 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Date of death is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)

(d) Street No. 20 Chrysler Place (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Herman W. Hardcoop Jr

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-16-6079

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Katherine Hardcoop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 21 1899

8. AGE: Years	Months	Days	If less than one day
44	3	27	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Own Business

FATHER

12. Name Herman W. Hardcoop

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Katherine (Unknown)

15. Birthplace Balto. Md.

16 (a) Informant Katherine Hardcoop

(b) Address 20 Chrysler Place - Catonsville

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3-22-44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Loudon Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1210 St Paul St.

(c) Date received MAR 21 1944 (Registrar) Huntington Williams Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 18th 1944, at 11:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1944 to 3-18 1944 and that I last saw him alive on 3-18 1944

Immediate cause of death Coronary Thrombosis — Duration Day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jesse E Stonesifer M. D.

Address Catonsville Date signed 3/20

Jas. H. Howell

G 15296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 15296

94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LEAVE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 2 — 29
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3943 Canterbury Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Henry Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1864

8. AGE: Years	Months	Days	If less than one day
79	4	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business At Home

FATHER
12. Name Mitchell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bowling
15. Birthplace Baltimore

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 21 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 9 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1943, to Mar. 20 1944, and that I last saw her alive on Mar. 20 1944.

Immediate cause of death	Duration
Coronary Thrombosis	10 days
Due to	
Due to	
Pneumonia, mild, central	
Other Conditions arteriosclerosis	2 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 333 N. Paca St. Date signed

VS 3

0

15297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 15297

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Carolina St.

(c) Hospital or institution: St Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 6309 Windsor Mill Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frank E Pitman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of ~~husband or~~ wife Ella M. Pitman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29th 1874

8. AGE: Years	Months	Days	If less than one day
69	2	21	hr min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Building

FATHER

12. Name Ezra Pitman

13. Birthplace Md

MOTHER

14. Maiden Name Unknown

15. Birthplace -

16 (a) Informant Clarence Pitman

(b) Address 1318 Ramblewood Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/23/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Lorraine

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

MAR 21 1944 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 19 44 at 1:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Generalized Peritonitis — Duration - 2 da

Due to Radical Resection of Rectum for Carcinoma — 4½ mo

Due to

Other Conditions Arteriosclerotic Cardiovascular Disease

(Include pregnancy within 3 months of death)

Date of operation 11/22/43 Exploratory 11/17/44 Radical Resection

Major findings of operation: Carcinoma - Recto Sigmoid Grading 3 Perirectal Involvement

of autopsy: Autopsy Refused

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Melvin J. Jaworski M.D.

Address St Joseph Hospital Date signed 3/20/44

G 15298

AB-86531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15298 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Homewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John J. Devine

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25-1876

8. AGE: Years 67 | Months 9 | Days 22 | If less than one day: hr min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name John J. Devine (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Murrey
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Wilhom Funeral Dir
(b) Address 1217 W Pratt St

19 (a) MAR 21 1944 (Date rec'd by registrar) (b) Huntington Printing Co., Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18 1944, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1944 to 3-18 1944, and that I last saw h (him) alive on 3-18 1944.

Immediate cause of death: Lobular Pneumonia — Duration: 2

Due to

Due to

Other Conditions: Bulbal Nervous System Syphilis — Duration: 7
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathne M. D.
Address B.C.H. Date signed 3/20/44

G 15299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15299 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5027 Frederick Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5027 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick L. Nevon

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-01-5824

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mayette F. Nevon
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Mar 26-1899

8. AGE: Years	Months	Days	If less than one day
44	11	22	hr. min.

9. Birthplace Baltimore, Md (Town, county and state)
10. Usual Occupation Iron Worker
11. Industry or business Detrick Son.

FATHER
12. Name Frederick Louis Nevon
13. Birthplace Maryland

MOTHER
14. Maiden Name Sophia Alice
15. Birthplace Maryland

16 (a) Informant Mrs Mayette L. Nevon
(b) Address 5027 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 22/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore, Md.

18 (a) Funeral director F. B. Wippert Son
(b) Address 700 Eastern Ave

MAR 21 1944

19 (a) Local registrar (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 18 1944, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30, 1944, to March 18, 1944, and that I last saw him alive on March 18 1944.

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to Angina Pectoris	8 Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliot W Rahmm M. D.
Address 3432 Frederick Ave (Date signed)

G 15300 ✓ G 15300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Woodland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA LEBERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Poland

MOTHER
14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-44 (month) (day) (year)
(c) Cemetery or crematory Wood. Beth.
Location Silver Spring Md.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) Date received by Registrar MAR 21 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1944, at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1944, to 3-19 1944, and that I last saw h alive on 3-19 1944.

Immediate cause of death Cardiorespiratory failure — Duration

Due to Marked toxemia

Due to Intestinal obstruction

Other Conditions Arteriosclerotic cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Mesenteric thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. Zuyus M. D.
Address Sinai Hospital Date signed 3-20-44

S 15301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15301
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Yes
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Prince Georges
(a) State Md (b) County Howard
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 363 Main Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Kroop

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Michael Kroop
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Michael Kroop.
(b) Address

17 (a) Burial (b) Date thereof 3-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Phil Rd & Hamilton Ave

18 (a) Funeral director Jack Louis Inc
(b) Address 1439 E. Baltimore St

19 (a) MAR 21 (b) 1944
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-44 19XX, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Cerebral Concussion

Due to

Other Conditions Multiple fractures, lacerations, contusions & bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-19-44 at 4:30 P.M. (Hour)
(b) Where did injury occur? North Blvd & Montgomery Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Skidded, collided and struck Wagon

23. Signature Howard J. Knowles M.D.
Medical Examiner.
Date signed 3-20-44

VS 161

G 15302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 15302 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 Burnett St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 Burnett St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Caroline Luedtke

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife John Luedtke 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1860

8. AGE: Years	Months	Days	If less than one day
83	4	3	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Marx
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Mr. August Luedtke
(b) Address P.O. Blue Bunny Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 21/44 (month) (day) (year)
(c) Cemetery or crematory Family Cemetery
Location 4th Dist. Hebron Md.

18 (a) Funeral director Fred. A. Krause & Son
(b) Address 216 E. Charles St.

19 (a) (Date received by registrar) MAR 21 1944 (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/ 1944 to 3/18 1944 and that I last saw her alive on 3/17 1944.

Immediate cause of death
Broncho-pneumonia

Duration 7 days

Due to

Due to

Other Conditions Hypertensive cardio vascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

? PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 3/20/ 1944

G 15303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

114E

G 15303
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 W. Henrietta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland Samuel Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5, 1938

8. AGE: Years 6 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Roland Hamm
13. Birthplace Balto md

MOTHER
14. Maiden Name Augustus Cunningham
15. Birthplace N. C.

16 (a) Informant Augustus Cunningham
(b) Address 202 W Henrietta St

17 (a) Burial (b) Date thereof 3/21/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Calvary
Location B. & O. Co. Md

18 (a) Funeral director David T Burch
(b) Address 108 N Montgomery St

19 (a) (Date rec'd by registrar) MAR 21 1944 (b) Timothy J. Riordan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 3:45 A M

21. I certify that I took charge of the remains described above, held an Investigation thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Dus death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic interstitial pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 18 1944

G 15304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1278

✓ G 15304 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard + Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ dy

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3401 Southern Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Fredk. H. Wiechmann (FREDERICK. H. WIECHMANN)

3 (b) If veteran, name war Spanish-American

3 (c) Social Security Account No 213-09-9855

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Caroline Wiechmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65 Months 6 Days 11 If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, County, and state)

10. Usual Occupation Chief Engineer

11. Industry or business Baltic Enamel Stamping Co.

FATHER 12. Name John Wiechmann

13. Birthplace Germany

MOTHER 14. Maiden Name Marguerita

15. Birthplace Germany

16 (a) Informant Helen Wiechmann

(b) Address 3401 Southern Ave, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 24. 1944 (month) (day) (year)

(c) Cemetery or crematory Metern

Location Baltimore, Maryland

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Road

19 (a) ..... (b) .....

(Date received by registrar) MAR 21 1944 Huntington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1944, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1944 to 3/20 1944 and that I last saw him alive on 3/20 1944.

Immediate cause of death Respiratory failure. — Duration 1 Day

Due to Uremia or hypostatic congestion — 4 days

Due to Post-operative gangrene gall-bladder. — 6½ Dys

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/13/44

Major findings of operation: Gangrenous gall-bladder

of autopsy: Cardio-hepato- and degenerative

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Alfred J. Nelson M. D.

Address University Hospital Date signed 3/20/44

G 15305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 15305 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 E. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 64

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Rogers Ave 2246 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily A. Wagner

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles H. Wagner

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) May 31st 1869

8. AGE: Years 74 | Months 9 | Days 20 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Wm H. Collier
13. Birthplace Md.

MOTHER
14. Maiden Name Melvina Collier
15. Birthplace Md.

16 (a) Informant William E. Wagner
(b) Address 1821 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 22 44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Md.

18 (a) Funeral director Loraah Funeral Home
(b) Address 7401 Belair Rd.

19 (a) MAR 24 1944 (Date filed by registrar) (b) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944. at 5-30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18- 1944. to 3-20- 1944. and that I last saw her alive on 3-19- 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunt Fitzgerald M. D.
Address 613 E. Nicholas Date signed 3-24-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15306 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3115 GWYNN FALLS PARKWAY.
(c) Hospital or institution: NO
(d) Length of stay in hospital or inst. (yrs., mos., or days) NO 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND. (b) County
(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 GWYNN FALLS PARKWAY (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE AGNES KOHLHEPP.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widowed

6 (b) Name of husband ~~or wife~~ Henry J. Kohlhepp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1870

8. AGE: Years	Months	Days	If less than one day
74	2	1	hr. min.

9. Birthplace Md. (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Arthur
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Boyle
15. Birthplace Ireland

16 (a) Informant Mrs. T. Jos. Doyle
(b) Address 3115 Gwynn Falls Pkwy.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.
18 (a) Funeral director Martin Fahey & Son
(b) Address 1827 W. North Ave.
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 20 1944, at 12.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 18 1944, to MAR 20 1944, and that I last saw her alive on MAR 20 1944.

Immediate cause of death	Duration
BRONCHIO PNEUMONIA.	
(INFLUENZA) MARCH 18	19.44.
Due to CHRONIC MYOCARDITIS	1943
Due to ARTERIOR SCLEROSIS	1943.
Other Conditions NONE	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Chas. P. Clautice M. D.
Address 3013 ST PAUL ST. Date signed 3/20/44

G 15307
AB-86336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

G 15307
Registered No.

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Be sure that information given in each item is complete and correct. Data regarding length of residence and age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos. 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 W. Baltimore St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Fuller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1861

8. AGE: Years	Months	Days	If less than one day
83	2	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Martin Shriebar (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Josefa Zeitlar (D)
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd.

18 (a) Funeral director John Conway & Son
(b) Address 901 03 Pennsylvania Ave

19 (a) MAR 21 1944 Registrar
(Date filed by registrar)

VS 150 To be approved by the Medical Examiner Howard J. Mullis, Jr M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20 1944 at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5, 1944 to Mar 20 1944, and that I last saw her alive on Mar 19 1944.

Immediate cause of death	Duration
Cardiac failure -	6 wks.
Due to Arteriosclerotic C.V.D.	?
Due to Fractured Neck of Left Femur	6 wks.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Femoral Thrombosis -
of autopsy: Pulmonary Embol.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Feb 5 1944 (Month) (Day) (Year) ? (Hour)
(c) Where did injury occur? (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Fall in back yard.

23. Signature Jos. J. Sheppard M. D.
Address Balto City Hosp Date signed Mar 20 1944

G 15308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15308 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Cole St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry J. Brown

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife ✓
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Dec 25 1943

8. AGE: Years	Months	Days	If less than one day
	3 2	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Tire
11. Industry or business

FATHER
12. Name Geo. E. Brown
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Evelyn Kessler
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Geo. E. Brown
(b) Address 1605 Cole St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John F. Bowen & Son
(b) Address 2010 Wilkens Ave

19 (a) MAR 21 1944 (Date rec'd by registrar) (b) Huntington Hilltop Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1944, at 4:50 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCally M.D. Medical Examiner.
Date signed 3/20/44.

VS 151

correct age is especially important. Physicians: please

15309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G 15309

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME Frank Gattis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mary -
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Aug. 6, 1884

8. AGE: Years	Months	Days	If less than one day
59	7	11	hr. ..... min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Gattis
13. Birthplace Tenn.

MOTHER
14. Maiden Name Mary Thornton
15. Birthplace Va

16 (a) Informant Mary Gattis
(b) Address 27 N. Spring St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location .....

18 (a) Funeral director Percy O Watson
(b) Address 1990 Edmondson Ave
(c) Huntington Hill Cemetery Md.

MAR 21 1944
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944, at 6:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma
Hemorrhage, Spont.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 18, 1944

VS 151

Please correct age is especially important. Registrar

G 15310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15310 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 239 W. Lanvale St.

(c) Hospital or institution:

none

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 239 W. Lanvale St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME William Gilbert Horn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Eleanor Chase

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) August 21, 1884

8. AGE: Years	Months	Days	If less than one day
59	6	28	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER | 12. Name John H. Horn

13. Birthplace Baltimore, Md

MOTHER | 14. Maiden Name Elizabeth Heym

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Eleanor C. Horn

(b) Address 239 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1600 Eutaw Place

19 MAR 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1938 to Mar 19 1944 and that I last saw h[illegible] alive on 3/19 1944

Immediate cause of death Coronary Thrombosis — Duration 12 Yrs

Due to Myocarditis Chronic Interstitial — Duration Gradual

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Hoadley

Address 1403 Park Ave. Date signed 3/22/44 M.D.

G 15311 ✓ G 15311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3230 Kenwick Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3230 Kenwick Road. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William F. Bosom.

3 (b) If veteran, name war 1st W.W.

3 (c) Social Security Account No. 217-09-1189

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Bosom.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22, 1895

8. AGE: Years 48 | Months 9 | Days 29 | If less than one day: hr. ..... min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Auxiliary Police

11. Industry or business Camp Hol

FATHER: 12. Name Thomas F. Bosom.
13. Birthplace Maryland.

MOTHER: 14. Maiden Name Ida V. Jeffries.
15. Birthplace Maryland

16 (a) Informant George Edward Smith
(b) Address 3230 Kenwick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Edward F. Bowman
(b) Address 3665-17 Edmondson Ave

19 (a) (Date received by registrar) MAR 21 1944 (b) Huntington Williamsport, Md.

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1943 to 3/21 1944. and that I last saw h[illegible] alive on 3/19 1944.

Immediate cause of death	Duration
Acute Cardiac dilatation	1 hr.
Due to Chronic myocarditis a	
Due to hypotension	2 yrs
Other Conditions \	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide \
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. Coles
Address 47 Fulton Date signed 3/21/44

G 15312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 15312 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3821 Hickory Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3821 Hickory Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Evans.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow.

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1856

8. AGE: Years	Months	Days	If less than one day hr.	min.
87	10	9		

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Bates
13. Birthplace Maryland.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Laurence M. Williams
(b) Address 3821 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22/44 (month) (day) (year)
(c) Cemetery or crematory Hereford Baptist
Location Hereford Md.

18 (a) Funeral director Edmund H. Donovan
(b) Address 3615-17 Eastern Ave

19 (a) (Date received by Registrar) (b) Huntington Md. (Registrar)

MAR 21 1944

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1944, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1944 to 3-20 1944, and that I last saw h[er] alive on 3-20 1944.

Immediate cause of death Arteriosclerotic C V D — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence J. Simmons MD

Address 3711 Fall Rd Date signed 3-21-44 M. D.

G 15313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

Registered No. G 15313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5235 Harkaway Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES KANE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Martha Kane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14, 1869

8. AGE: Years	Months	Days	If less than one day
74	4	5	hr. min.

9. Birthplace Maryland
(town, county, and state)
10. Usual Occupation Retired
11. Industry or business Labour (Balto City)

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant James T. Kane
(b) Address 1136 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 22/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Thos. W. DeSoto
(b) Address 3615-17 Chestnut Ave

19 (a) MAR 21 1944 (Date received by registrar) (b) Registrar

VS 151

PLEASE correct age is especially important. Physicians, please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19, 1944, at 8:32 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed 3-18-44

G 15314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G 15314 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 BAKER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town ✓ BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 BAKER. ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CONRAD - SCHMEHL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife WILHELMINA, SCHMEHL 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) SEPT-14-1868

8. AGE: Years	Months	Days	If less than one day
75	6	5	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation GROCER.
11. Industry or business SELF.

FATHER
12. Name NOT KNOWN
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant CARL SCHMEHL
(b) Address CAMPFIELD RD - PIKESVILLE MD.

17 (a) BURIAL. (Burial, cremation, or removal) (b) Date thereof 3 - 22 - 44 (month) (day) (year)
(c) Cemetery or crematory ST. PAULS. CEM
Location VIOLETSVILLE MD

18 (a) Funeral director Wm Chas A Gr Rohde
(b) Address 2327 Edmondson Ave

19 (a) (Signature of registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 19 1944, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944. to MARCH 19 1944. and that I last saw h/M alive on MARCH 19 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 3 hours

Due to

Due to Arteriosclerosis — 5 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Arthur J Davis M. D.
Address 800 W 34th St Date signed 3-20-44

✓ G 15315

G 15315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G 15315

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1912 Braddish Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1912 Braddish Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOTTIE CATHERINE WOOTTEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Uriah M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1887

8. AGE: Years	Months	Days	If less than one day
57	1	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Deacon

13. Birthplace Md.

MOTHER 14. Maiden Name Emma --

15. Birthplace Md.

16 (a) Informant Mr. Uriah M. Wootten

(b) Address 1912 Braddish Ave. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) MAR 21 1944 (Date received by registrar) Hunter Jr. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1944, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1944, to 3/18 1944, and that I last saw h[illegible] alive on 3/18 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	10 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry O Russell M. D.

Address 3902 Greenland Rd Balto 15 Date signed 3/20/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. C 15316

~~C 15316~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Woodlea Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto; (If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Woodlea Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLA RINK

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1868

8. AGE: Years	Months	Days	If less than one day
75	10	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name -- Stevens
13. Birthplace unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Miss Florence Rink
(b) Address 3907 Woodlea Ave. 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) MAR 21 19 44 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 19 44 at 11:35 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 19 44 to March 19 1944. and that I last saw her alive on March 18 19 44.

Immediate cause of death Cerebral Hemorrhage and Uraemia — Duration 2 days

Due to Chronic Interstitial Nephritis — 2 years

Due to Arterial Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Comenberg M. D.
Address 2025 Eldorado Ave Date signed 3/20/44

G 15317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15317 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 S. Linwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 S Linwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John G Reckenberger
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: Catherine
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1366
8. AGE: Years 78. Months Days If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Can Maker
11. Industry or business

FATHER
12. Name ?
13. Birthplace Germany.

MOTHER
14. Maiden Name ?
15. Birthplace Germany.

16 (a) Informant John Reckenberger
(b) Address 3001 East ave

17 (a) Bu (Burial, cremation, or removal) (b) Date thereof 3-22-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North ave - East

18 (a) Funeral director John J Duda
(b) Address 2829 Hudson st.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944 at 8:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1944 to 3/20 1944 and that I last saw her alive on 3/17 1944.

Immediate cause of death: Hemiplegia & Apoplexy — Duration 4 days
Due to: Arteriosclerosis generalized
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Klimas M. D.
Address 2623 E. Monument Date signed 3/20/44

G 15318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 S. Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 S. Luzerne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Szrmanskr (or) Szrmanski

3 (b) If veteran, name war No.

3 (c) Social Security Account No. 212-10-1735

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Katie (or) Katherine

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Sept (or) Oct. 1881

8. AGE: Years 62 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Joseph Szrmanskr

13. Birthplace Poland

MOTHER 14. Maiden Name Antoinette ?

15. Birthplace Poland.

16 (a) Informant Katherine Szrmanski

(b) Address 801 S. Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Gorsuch Hill Rd.

18 (a) Funeral director M. W. Eppel & Sons

(b) Address Lombard & Eutaw Sts.

19 (a) MAR 21 1944 (b) Registrar's signature Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7 1944 to Mar 18 1944 and that I last saw h alive on March 18 1944

Immediate cause of death: Myocardial degeneration, Chronic Prostatis, Bronchitis, Asthma

Duration: Cardiac for many months

Due to

Due to

Other Conditions Arterio-Sclerosis

(Include pregnancy within 3 months of death)

Duration: Months for many months

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. F. Rice M. D.

Address 24 S. Broadway Date signed Mar 20/44

G 15319

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G 15319 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6228 Ridgewood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6228 Ridgewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Davis

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1882 (74)

8. AGE: Years	Months	Days	If less than one day
70 62	2	14	hr. min.

9. Birthplace Brooklyn, New York
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name John Hensel
13. Birthplace New York

MOTHER
14. Maiden Name Lambe
15. Birthplace New York

16 (a) Informant Mrs. E. Davis
(b) Address 4413 Forest View Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director M. W. E. Dept. Inc.
(b) Address 7110 Belair Rd.

19 (a) MAR 21 1944 (Date rec'd by registrar) (b) Registrar No.

VS 151 For State Registrar by Howard J. Watkins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1944, at 4 A. M.

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy / Inspection / Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cardio-vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry [illegible] Ellenweber, M.D. M.D.
Medical Examiner.
Date signed March 21, 1944.

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15320 ✓ G 15320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 W Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 1/1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 W. Franklin St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Emeline Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife William Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day hr.	min.
77 8 6				

9. Birthplace a. a. Co. Md (Town, county, and state)
10. Usual Occupation Ware
11. Industry or business

FATHER 12. Name Peter Cook
13. Birthplace a. a. Co. Md.

MOTHER 14. Maiden Name Nagar
15. Birthplace a. a. Co. Md.

16 (a) Informant Bessie Brooks
(b) Address 1505 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St.

19 (a) MAR 21 1944 (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944, at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1944 to Mar 17 1944 and that I last saw her alive on Mar 15 1944.

Immediate cause of death: Arteriosclerosis Thrombocarditis — Duration: 2 W

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Howell M. D.
Address 601 N Carrollton Ave Date signed 3/20/44

G 15321

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15321
Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence E Henderson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1943

8. AGE: Years	Months	Days	If less than one day
	6 mo		hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER
12. Name Herman Robinson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Vashti Henderson
15. Birthplace Franklinton N. C

16 (a) Informant Vashti Henderson
(b) Address 1104 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 922 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1944, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho-pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Hunter J. Sulbrink M.D.
Medical Examiner.
Date signed 3/16/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M. D. B. 1208-9

15322

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 15322

CERTIFICATE OF DEATH

48 R

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 S. Carlton St., 3 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Agnes Connor

(a) Residence: No. 14 S. Carlton St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Connor

6. DATE OF BIRTH (month, day, year) Dec. 26, 1907

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
36	2	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME William Goss

14. BIRTHPLACE (city or town) (State or country) Balto. Md.

MOTHER

15. MAIDEN NAME Lillian Thomas

16. BIRTHPLACE (city or town) (State or country) Balto Md.

17. INFORMANT James Connor

(Address) 14 S. Carlton St

18. (BURIAL), CREMATION, OR REMOVAL

Place Mt. Auburn Cem. Date 3-22 1944

19. UNDERTAKER Mrs Kate P. Williams

(Address) 322 W. Lafayette St

Embalmer for Williams, M.D.

20. FILED ..... 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 17, 1944

22. I HEREBY CERTIFY, That I attended deceased from March 11, 1944, to March 17, 1944

I last saw h.. alive on March 16, 1944. Death is said to have occurred on the date stated above, at 7:45 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
(a) Uremia	6 wks
Other contributory causes of importance:	
Chronic Nephritis	?

Name of operation None Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury ..... 19....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) H. Donald Bando, M. D.

(Address) 2445 N. Milton Ave, Balto 7, Md.

INSTRUCTIONS. Should be carefully filled in, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

G 15323

15323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Do not use abbreviations. Physicians are required by law to report promptly to the Health Department the exact cause of death for every death which occurs in the practice of their profession. Their certificates must be filed with the Registrar of Vital Statistics, Room 303, City Hall, Baltimore, Md., before a burial permit will be issued. Any omission or incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 W. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 W Lafayette Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Richard William Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mamie S. Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 59 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert H Jackson
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Va

16 (a) Informant Mamie S. Jackson
(b) Address 220 N. Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs Katie L. Williams
(b) Address 822 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1944 to 3-19 1944 and that I last saw h alive on 3-17 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 9 days.

Due to Hypertension Cardiac Disease — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due ~~to external causes~~, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. H. Pifer M. D.
Address 5360 W. Fairfield Date signed 3-21-44

VS 3

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G 15324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 15324 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4507 Liberty heights ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4507 Liberty heights ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lewis Dain Myhre, Sr.

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 068-09-2087

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret E. Myhre

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) June 18, 1890

8. AGE: Years 53 | Months 9 | Days 1 | If less than one day: hr. min.

9. Birthplace Estherville, Iowa (Town, county, and state)

10. Usual Occupation Manager of manufacturing

11. Industry or business Westinghouse Elec Mfg Co

FATHER
12. Name Ole Myhre
13. Birthplace Norway

MOTHER
14. Maiden Name Gunhild Brunswold
15. Birthplace Norway

16 (a) Informant Mrs. Margaret E. Myhre
(b) Address 4507 Liberty heights ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23, 1944 (month) (day) (year)

(c) Cemetery or crematory
Location Glendale, Md.

18 (a) Funeral director Miller Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) MAR 21 1944 (Date rec'd by registrar) Registrar for Baltimore

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944, at 8.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1944 to March 19 1944 and that I last saw him alive on March 19 1944

Immediate cause of death
1) Recurrent coronary Thrombosis — Duration: 3 days.
Due to
Due to - Auricular Flutter — 2 days.
Other Conditions Hypertension, Heart Disease — 5yrs?
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4105 Liberty Heights Ave. Date signed

C 15325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

C 15325 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. yrs., mos., or days 3 D A
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irvin Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Rosa Bradley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8 - 886

8. AGE: Years 57 | Months 3 | Days 10 | If less than one day: hr min

9. Birthplace Maysville S. C (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Ervin Bradley
13. Birthplace S. C

MOTHER
14. Maiden Name Catherine
15. Birthplace S. C

16 (a) Informant Joseph Bradley
(b) Address 938 Harlem Ave

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 3-21-19++ (month) (day) (year)
(c) Cemetery or crematory
Location Wilmington N. C

18 (a) Funeral director Sam'l H. Chase & Son
(b) Address 638 N. Gilmor St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 5:50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Bronchitis, pulmonary edema

Due to

Other Conditions Sickle cell anemia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner

Date signed March 18, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G 15326

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-0-0.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 Brunt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ARDELL BROORS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Col

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 13, 1921

8. AGE: Years 22 | Months ? | Days - | If less than one day hr min

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frank Brooks
13. Birthplace Va.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Spencer Brooks
(b) Address 2005 Brunt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/44 (month) (day) (year)
(c) Cemetery or crematory Morristown Tenn.
Location

18 (a) Funeral director Geo. H Kinnan
(b) Address 130 3 [illegible]

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1944 at 5 15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of head

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-18-44 at 4-35 P.M.
(b) Where did injury occur? TAVERN! 2200 Pennsylvania Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Revolver

23. Signature T. J. Wallenmeyer Asst. Medical Examiner M.D.
Date signed 3-19-44

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15327

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hereford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6003 Eama ave (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth J. Kirsch

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Jos P Kirsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25 1860

8. AGE: Years	Months	Days	If less than one day
83	5	23 24	hr min.

9. Birthplace Balto County (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

MOTHER / FATHER
12. Name Adam Tapp
13. Birthplace Balto Co.
MOTHER
14. Maiden Name Margaret Martin
15. Birthplace Maryland

16 (a) Informant Jos Kirsch
(b) Address 6003 Eama ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem
Location North ave

18 (a) Funeral director J Heimann & Son
(b) Address 32 S. Broadway

19 (a) MAR 21 1944 (Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944, at 6P. M

21. I certify that death occurred on the date above stated, that I attended deceased from March 18 1944, to March 19 1944, and that I last saw h alive on March 18 1943.

Immediate cause of death — Duration
Renal Regurgitation — 1 day
Accompanied by — 1 day
Due to Chronic Nephritis — 1 day
Hypertension — 1 day
Due to Arteriosclerosis — 1 day

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the causes to which death should be charged statistically

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sol Strouse
Address 2878 Harford Rd Date signed 3/21/44 M. D.

Physician from Baltimore Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1647

G 15328
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto., Maryland
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Richwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE GRACE BECKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph F. Becker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years 27 | Months | Days | If less than one day: hr. min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles H. Corwin
13. Birthplace Michigan

MOTHER
14. Maiden Name Blanche Mohl
15. Birthplace Maryland

16 (a) Informant J. F. Becker
(b) Address 3108 Rockwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Bonaventure Rd

18 (a) Funeral director J. J. Feldmeier & Sons
(b) Address 1218 Light St.

19 (a) MAR 21 1944 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [✓] homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Wound, lacerated neck

Due to Suicide

Other Conditions mental dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary [✓] or contributing [ ] cause of death, fill in the following:
(a) Date of injury 3-18-44 at 5 P.M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury kitchen knife

23. Signature J. J. Wollenweber M.D.
Asst. Medical Examiner.
Date signed 3-16-44

G 15329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15329 332 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 W. Lanvale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 1427 W. Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Cromwell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife John A. Cromwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1823

8. AGE: Years	Months	Days	If less than one day
71	70		hr. min.

9. Birthplace Cambridge Md (Town, County, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Bromwell
13. Birthplace md

MOTHER
14. Maiden Name Mary —
15. Birthplace md.

16 (a) Informant Elsie Robinson
(b) Address 2549 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 24 44 (month) (day) (year)
(c) Cemetery or crematory Cambridge. Md
Location

18 (a) Funeral director James A Sayes
(b) Address 1142 W Fred St

19 (a) MAR 24 1944 (Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 20 1944 at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15- 1944 to 3-21- 1944 and that I last saw h er alive on 3-20 - 1944

Immediate cause of death (a) Myocarditis — Duration 4 days 3 days
Due to Influenza — 5 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. I. Cooper M. D.
Address 639 N. Carey St Date signed 3-21-44

G 15330

JO #86749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

G 15330 Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6508 Fait Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3 (a) FULL NAME

William Gast

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25, 1903

8. AGE: Years	Months	Days	If less than one day
40	9	25	hr ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business .....

FATHER

12. Name John Gast

13. Birthplace Maryland

MOTHER

14. Maiden Name Margaret Gieser

15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 23/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geiler INC.

(b) Address 403 S. WOLFE ST. Huntington Williamsport, Md

19 (a) ..... (b) ..... (Date rec'd by registrar) Registrar

VS 150

MAR 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1944, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1944 to 3-20 1944 and that I last saw him alive on 3-20 1944

Immediate cause of death

Carcinoma of Bladder — Duration 3 yrs

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Above with metastases

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Donald R. Lebb M. D.

Address Balto City Hosp Date signed 3-20-44

G 15331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 15334 Registered

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 E. 33RD. ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 E. 33RD. ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE SELLMAYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife JOHN SELLMAYER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 3-1885

8. AGE: Years	Months	Days	If less than one day
58	10	17	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name THEDORE VON RINTELN
13. Birthplace GERMANY

MOTHER
14. Maiden Name THERESA OHLE
15. Birthplace GERMANY

16 (a) Informant VICTOR VON RINTELN (BROTHER)
(b) Address 1601 E. 29TH. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 23/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 126

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 20 1944, at 5/30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1944 to March 20 1944, and that I last saw her alive on March 19 1944.

Immediate cause of death: Carcinoma Breast — Duration: 16 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Fa Stevens M. D.
Address 818 Harford Rd Date signed 3/21/44

correct age is especially important. Typewriter, pencil or pen may be used, but ink must be used. Do not write in margins or outside ruled lines. Use permanent black ink.

G 16332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15332 / 940

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN BLACKWELL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Mary Blackwell (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1877

8. AGE: Years	Months	Days	If less than one day
66	-	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business R. R. Retirement Board

FATHER
12. Name Blackwell
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa
15. Birthplace Maryland

16 (a) Informant James M. Blackwell (Son)
(b) Address 2103 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County, Md.

18 (a) Funeral director Joseph L. Locke, Jr.
(b) Address 1804 N. Central Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-18-44 at 5:15 P.M.
(b) Where did injury occur? 1927 Guilford Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall down the stairs at home.

23. Signature H. L. Wallenmeier M.D. Medical Examiner.
Date signed 3-14-44

15333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15333
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 N. Wolfe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town write RURAL and give town)
(d) Street No. 417 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Campbell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21-1878

8. AGE: Years 45 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Balto City (Town, county or state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John H Buck
13. Birthplace Balto

MOTHER 14. Maiden Name Jennie Green
15. Birthplace Balto City

16 (a) Informant Charles Campbell
(b) Address 417 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A & Co Rds

18 (a) Funeral director Robt F Mellin
(b) Address 1515 McElderry St

19 (a) (b) Registrar Huntington Williams, M.D.

MAR 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1944 at 12 night M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1st 1941 to March 17 1944, and that I last saw h alive on 3. 17. 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	48 hr
Due to Arterio. Sclerosis.	3 yrs
Due to Myocarditis	7 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. Signature Thos. H Maynard M. D.
Address 4. E. Read St Date signed 3/20/44
Vernon 7689

correct age is especially important. Physicians: please write the cause of death clearly. Typing

G 15334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G 15334

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1030 Mc Hoop Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Mc Hoop Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adele A. Brockmeyer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Matthew V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 3 1896

8. AGE: Years	Months	Days	If less than one day
47	11	15	hr. min.

9. Birthplace Ho Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry N. Kessler
13. Birthplace Md

MOTHER
14. Maiden Name Clementine Cook
15. Birthplace Md

16 (a) Informant Mr Joseph C. Brockmeyer
(b) Address 2412 Georgetown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J. Boyle
(b) Address 5[illegible] Harford Rd

19 (a) MAR 21 1944 (Date rec'd by registrar) (b) Huntington William Boyle

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 18 - 1944, at 10 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 19__, to 3/18 1944, and that I last saw h[illegible] alive on 3/18 1944.

Immediate cause of death Acute Cardiac Collapse — Duration
Due to Malignancy of Lung
Due to Metastasis of Liver
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Ashgrove St Date signed 3/21/44

15335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G 15335
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1824 Hope St
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 Hope St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Madalene Gaitley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): May 30. 1878
8. AGE: Years: 65 | Months: 9 | Days: 19 | If less than one day: hr. min.
9. Birthplace: Balto Md (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: John Schaeffer
13. Birthplace: Md

MOTHER
14. Maiden Name: Theresa Sparks
15. Birthplace: Md.

16 (a) Informant: Mr Joseph Gaitley
(b) Address: 1824 Hope St
17 (a) Burial: (Burial, cremation, or removal) (b) Date thereof: 3-22-44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location:
18 (a) Funeral director: Samuel J. Stumpf
(b) Address: 5305 Harford Rd

MAR 21 1944
(a) (b) (Date received by registrar)
Registrar

VS 180

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/19 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1943, to 3/19/1944, and that I last saw her alive on 3/18 1944.

Immediate cause of death: Carcinoma of Stomach — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Sol Smith
Address: 1223 E. North Ave
Date signed: 3/20/44 (M. D.)

G 15336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G 15336
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4700 Hartford Rd
(b) Street address 3120 Gaseonade
(c) Hospital or institution: Seton Maternity Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 3120
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Marion Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Andrew Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-1874

8. AGE: Years 69 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Ct Worker

11. Industry or business

FATHER
12. Name Wm Clark
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Va ~~Black~~ ?
15. Birthplace Va.

16 (a) Informant Nolan Pinkard
(b) Address 3120 Marion Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-44 (month) (day) (year)

(c) Cemetery or crematory Lebanon Baptist Cem
Location Alfonso Va

18 (a) Funeral director Donald Ross
(b) Address 5305 Harford Rd

MAR 21 1944
(Date filed by registrar) (Title) Secretary to Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1944 to Mar 19 1944, and that I last saw h alive on Mar 19 1944.

Immediate cause of death

Duration

Myocarditis — year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis A. Gaynor M. D.
Address 7 Wendover Rd. Date signed

VS 180

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15337 JANNINA BASSI G 15337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jannina Bassi

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Nick Bassi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1867

8. AGE: Years	Months	Days	If less than one day
76	8	26	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Divito
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Frank Di Carlo
(b) Address 419 E. North ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 23/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Washington D C

18 (a) Funeral director Samuel Mazza
(b) Address 5306 Hamilton Md

MAR 21 1944 Huntington Williams Jr.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944 at 5:45 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 21, 1944

15338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15338
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2307 Bryant Ave
(c) Hospital or institution:

13 → 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Riegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day hr.	min.
65				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David —
13. Birthplace Russia

MOTHER
14. Maiden Name Esther —
15. Birthplace Russia

16 (a) Informant Fanny Frankfagen
(b) Address 2307 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-44 (month) (day) (year)

(c) Cemetery or crematory Druid Hill Park
Location Park Ave & Hamilton Ave

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) MAR 21 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-44 19 . at 6.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944 to March 20 1944. and that I last saw h. alive on March 20 1944

Immediate cause of death Coronary Thrombosis — Duration 5 days

Due to arterio-sclerosis — Duration 5 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. H. Geppins
Address 2307 Eutaw Pl Date signed 3/24/44

G 15339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15339 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Radnor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 608 Radnor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. McManus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17 1876

8. AGE: Years 67 Months 5 Days 19 If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John J. McManus
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Linton
15. Birthplace Ireland

16 (a) Informant Annie Christy
(b) Address 608 Radnor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23 (month) 1944 (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Ave

18 (a) Funeral director John E. Mudge
(b) Address 800 E. Balto. St.

19 (a) MAR 21 1944 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944 at 5-20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943 to Mar. 19 1944 and that I last saw her alive on Mar. 18 1944

Immediate cause of death
Cerebral Hemorrhage — Duration 8 mos.
Due to Hypertension and Cardio- — 7
Due to vascular disease —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry F. Caruso M. D.
Address 5217 York Rd Date signed 3/20/44

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15340 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 635 E. 36th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 635 E. 36th St.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. [redacted] Byrne
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Jane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22 1864
8. AGE: Years 79 | Months 8 | Days 26 | If less than one day hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Soldier in U.S.A.
11. Industry or business
FATHER 12. Name Joseph Byrne
13. Birthplace Ireland
MOTHER 14. Maiden Name Mary Kane
15. Birthplace Ireland
16 (a) Informant James Byrne
(b) Address 635 E. 36th St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md
18 (a) Funeral director Thos. A. Madden
(b) Address 3005 Eastern Ave
19 (a) MAR 21 1944 (b) Hunting for Veterans
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18/1944 at 5P M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1944 to 3/18 1944 and that I last saw h[illegible] alive on 3-18 1944

Immediate cause of death Cerebral Hemorrhage Duration unknown
Due to Arteriosclerosis CVD 2 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Finnamore M.D.
M. D.
Address 3711 Fairfield Ave. Date signed 3-19-44

Profili

G 15341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G 15341

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Broadway & Fairmount Ave.

(b) Street address 2503 Chase St. 8

(c) Hospital or institution:

Church Home & Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs. & 30 min.

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2503 Chase Street (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Louis G Profiti

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Helen Profili

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 27, 1900

8. AGE: Years	Months	Days	If less than one day
43	8	23	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Clothes Designer

11. Industry or business

FATHER

12. Name Domenic Profili

13. Birthplace Italy

MOTHER

14. Maiden Name Angelo Marinzo

15. Birthplace Italy

16 (a) Informant Wife

(b) Address 2503 Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Frank V. Pipitone

(b) Address 2818 E. Baltimore St

19 (a) MAR 21 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 7 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 19.44, to March 20 19.44, and that I last saw him alive on March 20 19.44.

Immediate cause of death	Duration
Pneumonia	
Due to terminal Septicemia	
Due to subacute bact. endocarditis	
Other Conditions Carcinoma of liver	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: subacute bact. endocarditis; carcinoma of liver

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature H. Williams

Address Church Home & Hospital Date signed 3/20/44 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G 15342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15342 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 N. Kenwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Campbell Guckert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John P. Guckert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1868

8. AGE: Years	Months	Days	If less than one day hr.	min.
76	1	16		

9. Birthplace Elmira, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Campbell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Eichelberger
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Helen Chaney
(b) Address 123 N. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 22 44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location 5608 Dogwood Road

18 (a) Funeral director Frank J. Pipitone
(b) Address 2818 E. Baltimore Street

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, Registrar

R 21 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1943 to 3-19 1944, and that I last saw her alive on 3-19 1944.

Immediate cause of death	Duration
ARTERIOSCLEROSIS	3 YRS
NEPHRITIS	1 YR.
Due to ELEPHANTIASIS	4 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Kavanagh MD M. D.
Address 3328 McElderry Date signed 3-20-44

correction is especially important. Physicians: please write the cause of death clearly and legibly.

G 15343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G 15343
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 N Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTHA LEWIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife Cleveland Lewis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 6, 1893

8. AGE: Years	Months	Days	If less than one day
50	9	12	hr. min.

9. Birthplace Hobson, Va. (Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Thomas Wright
13. Birthplace Va

MOTHER
14. Maiden Name Nancy ?
15. Birthplace —

16 (a) Informant Cleveland Lewis
(b) Address 521 N. Bond St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location
18 (a) Funeral director Elroy C. Wilson
(b) Address 1090 Pleasant Ley ave
19 (a) MAR 21 1944 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18 19 44, at 4 50 PM

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremia nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Attending Medical Examiner.
Date signed 3-18-44

VS 181

Correct age is especially important. Physicians, please write in the number of years, not the age group.

G 15344

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lyndenhurst Hospital G.T.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 1308 Bocaave
(If outside city or town limits, write RURAL and give town)
Street No. Walther
(If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Billie Sue Andrews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-40

8. AGE: Years 4 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Rogers Andrews
13. Birthplace Balto Co. Md

MOTHER
14. Maiden Name Billie
15. Birthplace Arkansas

16 (a) Informant R. Kay
(b) Address Lyndenhurst Hosp

17 (a) (Burial, cremation or removal) (b) Date thereof 3 21 44
(month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3900 Frederick Rd.

18 (a) Funeral director Henry McWilliams
(b) Address 4101 Edmondson Ave

19 (Date received by registrar) 21 1944 Huntington Williams Asst. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1944, at 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1944 to 3/19 1944 and that I last saw h[illegible] alive on 3/19 1944

Immediate cause of death Resp. failure — Duration

Due to Cerebral edema

Due to measles encephalitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rose Kay
Address Lyndenhurst Date signed 3/21/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15345 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 894 Tyson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 894 Tyson St. (If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Cooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
49	5	6		

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Anna Cooper
(b) Address 894 Tyson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAR 21 1944 (Registered by registrar) (b) Huntington Williams, M.D.
Address 817 N. Monta Ave

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19 1944, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 4 1944 to Mar 17 1944
and that I last saw h alive on 19

Immediate cause of death Lobar Pneumonia — Duration 13 Days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, etc.) While at work?
(e) Means of injury
23. Signature H. C. Pelletreau M. D.
Address 817 N Monta Ave Date signed

G 15346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15346 Registered No. 82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 N. 37th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 N. 37th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Ella Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27-1863

8. AGE: Years 80 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Philadelphia, Penna. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

MOTHER / FATHER

12. Name Charles Smith
13. Birthplace England
14. Maiden Name Mary Theresa Burke
15. Birthplace Maryland

16 (a) Informant P. J. Frazer
(b) Address 5201 Eugene Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3691 Falls Road

MAR 21 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18- 1944, at 10-50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10- 1944, to 3-18 1944 and that I last saw h[illegible] alive on 3-18 1944.

Immediate cause of death: Pneumonia
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 9 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Morrissey M.D.
Address 3672 Roland Ave. Date signed 3/20/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correctly and legibly. Physicians: please write the causes of death clearly and legibly. Occupation is especially important.

G 15347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15347 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Please answer all questions fully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Pelham Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Pelham Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Middendorf

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frank S. Middendorf
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 31th, 1870

8. AGE: Years	Months	Days	If less than one day
74	1	17	18 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Anton Behlman
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Athman
15. Birthplace Germany

16 (a) Informant Miss Marie Middendorf
(b) Address 3014 Pelham Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19th, 1944, at M

21. I certify that death occurred on the date above stated; that attended deceased from March 19 44 to March 19 44 and that I last saw her alive on Mar 19 19 44

Immediate cause of death: Chronic Interstitial Nephritis — Duration

Due to Senility

Due to Hypertension

Other Conditions Atheroscleroses

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. Anderson M. D.
Address 3001 Shannon Drive Date signed 3/30/44

G 15348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15348 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Belmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FATHER Harmon C. Hilty

3 (b) If veteran, name war: 1st World War

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Elsie B Hilty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 14, 1895

8. AGE: Years	Months	Days	If less than one day
49	2	6	hr. min.

9. Birthplace: Baltimore Md. (Town, county and state)
10. Usual Occupation: Railroad Police
11. Industry or business: Penna Railroad Co

FATHER
12. Name: Charles E Hilty
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Mary Kenny
15. Birthplace: Balto Md.

16 (a) Informant: Mrs Elsie B Hilty
(b) Address: 2903 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cemetery
Location: Edmondson Ave.

18 (a) Funeral director: Albert L Hilty Jr
(b) Address: 1606 N Chester St

19 (a) MAR 21 1944 (Date filed by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 1:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner
Date signed March 20, 1944

VS 161

15349

AB-70719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. C 15349

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs-2mos-10days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Coake

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife Myrtle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2-1881

8. AGE: Years 62 | Months 4 | Days 10 | If less than one day: hr min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name James Coake (D)
13. Birthplace N.Y.

MOTHER: 14. Maiden Name Elizabeth ? (D)
15. Birthplace N.Y.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location BURIAL PERMIT MAR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 21 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1944, at 8:07 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1943, to 3-12 1944, and that I last saw h[illegible] alive on 3-12 1944.

Immediate cause of death: Uremia — Duration: ?

Due to Hypertensive cardio vascular disease — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattner
Address B.C.H. Date signed 3/16/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

0802

G 15350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15350 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 E. Birckhead St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 E. Birckhead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Edwards.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Ellis H. Edwards

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1881

8. AGE: Years 62 | Months 7 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Charles Hamilton
13. Birthplace Md.

MOTHER
14. Maiden Name Susan —
15. Birthplace Md.

16 (a) Informant family
(b) Address 127 E. Birckhead St.

17 (a) S. (b) Date thereof 3-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Ave.

18 (a) Funeral director James L. McAuley
(b) Address 130 E. Lanvale.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 21 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944 5:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4. 5 1942 to 3. 19 1944 and that I last saw her alive on 3. 19 1944.

Immediate cause of death	Duration
Acute Pulmonary Edema	1 day
Due to	
Due to Cerebral Hemorrhage	3 15 44
Other Conditions Cardiac Hypertension	Don't Know.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Norris M. D.

Address 107 East west St Date signed 3.21.44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 15351
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 W. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Parish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-44.

8. AGE: Years	Months	Days	If less than one day
	1	4914	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Julius Parish
13. Birthplace Norfolk Va.

MOTHER
14. Maiden Name Lenora Franklin
15. Birthplace Norfolk Va.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 21 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3-1944, to 2-17 1944, and that I last saw him alive on 2-16 1944.

Immediate cause of death — Duration

49 days Due to Prematurity and Mal nutrition

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr J. Bradshaw Higgins M.D.
Address 2248 Madison Ave Date signed 3/17/44

VS 150

0805

15352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 15352
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Wrightson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1944

8. AGE: Years	Months	Days	If less than one day
		1	35 hr. 45 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Chester R. Wrightson
13. Birthplace

MOTHER 14. Maiden Name Jufaed
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL MAR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 21 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1944, at 11:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris L. Katzeff M. D.
Address Sinai Hosp. Date signed 3/14

0804

15353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G 15353
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3727 Columbus Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Berman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1944

8. AGE: Years	Months	Days	If less than one day
			21 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morton Berman
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Anna Hurwitz
15. Birthplace Baltimore, Md.

16 (a) Informant Morton Berman
(b) Address 3727 Columbus Drive

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 21 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAR 21 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1944 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1944 to 3/11 1944 and that I last saw him alive on 3/11 1944.

Immediate cause of death: Congenital Heart Disease.
Due to: Auricular Septal Defect
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation:
Major findings of operations:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julie M. Wells M. D.
Address 222 N. Eden St. Date signed 3/11/44

VS 2

0803

G 15354

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G 15354 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1445 Towson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1445 Towson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wolf.

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Anna Wolf
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Oct. 24 1862

8. AGE: Years 81 | Months 5 | Days 29 | If less than one day: hr. min.

9. Birthplace Germany (Town, County and State)
10. Usual Occupation Retired Labourer.
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Mary Reichenberg
(b) Address 1445 Towson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location A.A. Co. Md.

18 (a) Funeral director Charles F Dill
(b) Address 1501 E Fort Ave.

MAR 21 1944 (Date rec'd by Registrar) (b) Huntington Hillsdale, Md. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6th 1944 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3rd 1942 to March 6th 1944, and that I last saw h alive on March 1 1944.

Immediate cause of death: Pulmonary Edema — Duration: 2 days
Due to: Cardio Vascular Disease
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Faulkner M. D.
Address 1104 Milton Date signed 3/21/44

G 15355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 15355 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2750 Alameda Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2750 Alameda Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Paul Eshrondt

3 (b) If veteran, name war No

3 (c) Social Security Account No. 215-03-3154

4. Male X | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Amanda R Eshrondt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1891

8. AGE: Years 53 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Ind Mon Retired

11. Industry or business Liberty Oil Co

FATHER 12. Name (Unknown) Eshrondt
13. Birthplace Germany

MOTHER 14. Maiden Name Julia (Unknown)
15. Birthplace Germany

16 (a) Informant Amanda Eshrondt
(b) Address 2750 Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Wilson & Lyons
(b) Address 1217 St Paul St

MAR 21 1944 (Date received) (b) Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 3 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1940 to Mch 18 1944.
and that I last saw him alive on Mch 18 19 44

Immediate cause of death: Coronary occlusion — Duration: 4 yrs

Due to: Coronary disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fritz J Klinzey M. D.
Address 2700 Hartford Rd Date signed Mch 19 1944

PLEASE WRITE PLAINLY with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G 15356 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 E 20th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2452 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B Kelly

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced U. Widower

6 (b) Name of husband or wife Virginia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 1879

8. AGE: Years 65 | Months 1 | Days 6 | If less than one day min.

9. Birthplace Clifton Heights, Pa (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business Lond Balt Hotels

MOTHER / FATHER
12. Name Thomas Kelly
13. Birthplace Ireland
14. Maiden Name Sarah Kelly
15. Birthplace Ireland

16 (a) Informant Mrs Catherine Monaghuffe
(b) Address 408 E 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore City

18 (a) Funeral director Wilson Funeral Home
(b) Address 219 E Fayette St

19 (a) MAR 23 1944 (b) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944 at 4:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1944 to 3/18 1944.
and that I last saw him alive on 3/18 1944.

Immediate cause of death Myocardial insufficiency — Duration 3 yrs.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Grayton M.D.
Address 3963 Greenmount Ave. Date signed 3/21/44

M. D.

VS 150

FILLING WRITE LEGIBLY. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 15357 Registered No. 939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 E 20th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 E. 20th. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie (Lily) M. Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Walter H. Fields

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) [illegible]

8. AGE: Years 67 | Months 0 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Charles [illegible]
13. Birthplace Balto.

MOTHER
14. Maiden Name Annie Lee
15. Birthplace Balto. Md.

16 (a) Informant Lucian M. Fields
(b) Address 1102 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory Bal'o
Location

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St

19 (a) (b) (Date rec'd by registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944 at 2 P.M.

21. I certify that I took charge of the remains described above, held an Enquiry Inquest Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fontaine M.D. Medical Examiner
Date signed March 27 1944

C 15358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 15358

1178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Front Royal (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 E. Main St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Cammer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Phillip
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-22-88

8. AGE: Years 55 | Months 8 | Days 29 | If less than one day: hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Christian Disch
13. Birthplace N.Y.

MOTHER
14. Maiden Name Ellen Constable
15. Birthplace England

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date then Mar 24 1944 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Front Royal Va

18 (a) Funeral director Edmund Mac Nabb
(b) Address Catonsville Md

MAR 22 1944 Huntington Pittman M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1944 at 4.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1943 to Mar 21 1944 and that I last saw h[illegible] alive on Mar 21 1944

Immediate cause of death Peritonitis — Duration

Due to Perforated Duodenal Ulcer

Due to Adhesions & stricture. Obstruction post-operative

Other Conditions Jaundice; Gastro enterostomy 12-20-43

Date of operation 2-12-44 2-25-44

Major findings of operation: Jud. ulcer, perf. Adhesions

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Johns Hopkins Hosp Date signed 3-21-44 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 15359 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or Town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 N. Ellamont St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Boy Trott (Baby Arthur William Trott)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/13/44

8. AGE: Years | Months | Days 9 | If less than one day — hr. — min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Jos. J. Trott
13. Birthplace Balto.

MOTHER
14. Maiden Name Doris Lang
15. Birthplace Balto.

16 (a) Informant Mr. John T. Trott
(b) Address 1528 N. Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 22 1944 (Date rec'd by registrar) (b) Hunting for Williams ??? (Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/44 19 , at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13-44 19 , to 3/21/44 19 , and that I last saw h[illegible] alive on 3/21/44 .

Immediate cause of death Asphyxia — Duration

Due to Prematurity

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Clyde Webster M.D.
Address Franklin Square Hospital Date signed 3/21/44

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G 15360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G 15360 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga Streets
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Arunah St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-3376

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Late Kate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day hr.	min.
54	-	7		

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation Painting House

11. Industry or business

FATHER 12. Name Simon Snyder
13. Birthplace Russia

MOTHER 14. Maiden Name Re becca Margolis
15. Birthplace [illegible] Russia

16 (a) Informant Mrs Jean Grossman
(b) Address 526 N Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North ave

19 (a) Date received MAR 22 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/1944 at 1020 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to March 20 1944 and that I last saw him alive on 3/20 1944.

Immediate cause of death Cardio Respiratory Failure — Duration

Due to Bronchogenic Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Davis
Address Mercy Hospital Date signed 3/20/1944

G 15361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G 15361 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Aves.
(c) Hospital or institution:
Hebrew Home for Aged & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella Kaminetzky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed or divorced: Divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years: 60 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation housework

11. Industry or business

FATHER 12. Name Sylvan —
13. Birthplace Russia

MOTHER 14. Maiden Name —
15. Birthplace Russia

16 (a) Informant A. Contract
(b) Address 3613 Cottage Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3-23-44 (month) (day) (year)
(c) Cemetery or crematory Workmans Circle
Location Hebrew Nat. Carmel

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) MAR 22 1944 (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from February 11 1944, to March 20 1944, and that I last saw her alive on March 20, 1944.

Immediate cause of death: Carcinoma of stomach — Duration: 8-1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-8-43

Major findings of operation: Mass in the epigastrium.

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edmund Levin, M.D.

Address Levindale Date signed 3/20/44

G 15362

BALTIMORE CITY HEALTH DEPARTMENT V G 15362 Registered No.

CERTIFICATE OF DEATH 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Beverly Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Beverly Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Stanley alexandrowicz (alexander)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-20-6832

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years About 52 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Cold Presser

11. Industry or business Bethleham Steel Co,

FATHER 12. Name Frank

13. Birthplace Poland.

MOTHER 14. Maiden Name Frances Stolarska

15. Birthplace Poland

16 (a) Informant Mary Alexandrowicz

(b) Address 3205 Beverly Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-44 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location German Hill Rd

18 (a) Funeral director Wm. L. Fialkowski

(b) Address 2007 Eastern ave

19 (a) Registrar (Date received) MAR 22 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1944 to March 20 1944 and that I last saw h[im] alive on March 20 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Andrew Kunkowski M. D.

Address 2579 Eastern Date signed

ANDREW KUNKOWSKI

15363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

G 15363 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 N. Durham St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Durham. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Bush.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24th 18 3

8. AGE: Years	Months	Days	If less than one day
80	3 2	27	hr. min.

9. Birthplace Baltimore. Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Bush.
13. Birthplace Baltimore.

MOTHER
14. Maiden Name Ellen Holland
15. Birthplace Ireland

16 (a) Informant Joshua Bush.
(b) Address 1704 N, Durham St,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 24th 44 (month) (day) (year)
(c) Cemetery or crematory New Catherdral
Location Frederick Md.

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811 N. Wolfe St.

19. (a) (b)
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 21st. 1944, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10. 1944. to Mar 21 1944, and that I last saw h[illegible] alive on Mar. 20 1944.

Immediate cause of death	Duration
Uterine Carcinoma	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carol Fisher M. D.
Address 1828 N Mad ave. Date signed 3/22/44

Please write plainly, with CARBON INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Washington Williams M.D.

G 15364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 15364
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Brunt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
81	80		hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name John Gorden
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Willis
15. Birthplace Va.

16 (a) Informant Sarah Dixon
(b) Address 1811 Brunt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) I hereby [illegible] Registrar

MAR 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 11 A M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar pneumonia
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Feather M.D.
Medical Examiner.
Date signed March 18 1944

VS 151

15365
70 #84550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G 15365

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 & 24
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Douvall Lennon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Francis Lennon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1914

8. AGE: Years	Months	Days	If less than one day
29	6	9	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wannie
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lissie Gowins
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Removal to Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)

(c) Cemetery or crematory Bladensboro
Location North Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 3 1944 (Entered by registrar) Thurlington Williams Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1944, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27-1943 to 3-20-1944 and that I last saw him alive on 3-20-1944.

Immediate cause of death: Pulmonary Tbc.
Tbc. meningitis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Ehrlich M. D.
Address 49 to Eastern Ave Date signed 3-20-44

G 15366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 15366

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 31 | Months | Days | If less than one day hr. min.

9. Birthplace Jacksonville, N.C. (Town, county, and state)

10. Usual Occupation Defense Work

11. Industry or business Dry Dock

FATHER
12. Name Frank Humphrey
13. Birthplace ?

MOTHER
14. Maiden Name Ida White
15. Birthplace ?

16 (a) Informant Lizzie Dixon
(b) Address 625 George Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location Warsaw N.C.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAR 22 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner
Date signed March 21, 1944

VS 151

G 25367

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

Registered G 25367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 61
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 13 (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2113 Belair Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Margaret Neidert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Louis D. Neidert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/1868

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Henry Taylor
13. Birthplace Maryland

MOTHER
14. Maiden Name Minerva Hottel
15. Birthplace Virginia

16 (a) Informant Mrs. Gertrude Linker
(b) Address 2118 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wendell E. Humphreys
(b) Address 4704 E. Broadway

19 (a) MAR 22 1944 (Date rec'd by registrar) (b) Huntington Hill Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944 at 5 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1944 to 3/19 1944 and that I last saw h[illegible] alive on 3/19 1944

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerosis

Due to Old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/13/44

Major findings of operation: Ca. of Colon with Metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. B. Gray M.D.
Address Mercy Hosp Date signed 3/19/44

G 15368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 937

G 15368 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 N. Gilmore Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Kennedy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife late Lillian E. nee Chambers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name James A. Kennedy
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary A. McCarthy
15. Birthplace Balto. Md.

16 (a) Informant Walter L. Kennedy Jr.
(b) Address 3627 Coolidge Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 Old Frederick Rd.

18 (a) Funeral director Harry A. Wiebke
(b) Address 401 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20- 194X, at 9:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maldeis M.D.
Medical Examiner.

Date signed 3-20-44

G 15369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15369 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Wilkens Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dennis C. Mc Govern

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	/

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 2, 1941

8. AGE: Years	Months	Days	If less than one day
2	2	27	hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Mc Govern
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Loretta C. Graham
15. Birthplace Balto. Md

16 (a) Informant M. Charles Mc Govern
(b) Address 1700 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 old Frederick Rd

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Thurston Registrar

MAR 22 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-1944, at 9:30 AM

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strangulation -

Due to Food.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-20-44 at 1944 A M.
(b) Where did injury occur? 1700 Wilkens Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Food in upper Respiratory tract

23. Signature Howard J. Walker M.D. Medical Examiner.
Date signed 3-20-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15370 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3223 Kingsley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary A. Crist

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17, 1878

8. AGE: Years	Months	Days	If less than one day
66	2	2	hr. min

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Scott
13. Birthplace Maryland

MOTHER
14. Maiden Name Georgeanna
15. Birthplace Maryland

16 (a) Informant Husband
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd.

18 (a) Funeral director Harry A. Wetzke
(b) Address 4101 Edmondson Ave

19 (a) MAR 23 1944 (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18 1944, to Mar. 19 1944, and that I last saw h[illegible] alive on Mar 19 1944.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary Occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, etc.)
(e) Means of injury

23. Signature Wilbur H. Hosking, M.D.
Address St. Agnes Hosp. Date signed 3/19/44

G 15371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15371 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette + Payson Sts
(c) Hospital or institution:
Bon Secours

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Academy Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Judge

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Bertha M. nee Mae Farland 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 3, 1898

8. AGE: Years	Months	Days	If less than one day
45	11	16	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Tower Operator
11. Industry or business Beth. Shipbldg Co

FATHER
12. Name Wm L. Judge
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Rose C. McSherry
15. Birthplace Baltic. Md

16 (a) Informant Mrs. Bertha Judge
(b) Address 405 Academy Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 old Frederick

18 (a) Funeral director Harry F. Withe
(b) Address 4101 Edmondson Ave.

19 (a) MAR 22 1944 (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1944 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1944 to 3/19 1944 and that I last saw him alive on 3/19 1944.

Immediate cause of death	Duration
Hypostatic pneumonia	2 days
Due to Bronchogenic Carcinoma ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: Bronchogenic C.A.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Sumrod Boyer M. D.
Address Bon Secours Hosp Date signed 3/19/44

G 15372

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 15372 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Bayview Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 57 S. Eaton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Borgner

3 (b) If veteran, name war

3 (c) Social Security Account No. 175-05-1871

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary McFarlan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14-1892

8. AGE: Years	Months	Days	If less than one day
52	2	1	hr. min.

9. Birthplace Lebanon, Pa. (Town, county, and state)

10. Usual Occupation Mill Worker

11. Industry or business Porter Bros Mfg Co

FATHER
12. Name William Borgner
13. Birthplace Lebanon Pa.

MOTHER
14. Maiden Name Mary D. Cole
15. Birthplace [illegible] Richmond, Va.

16 (a) Informant Raymond B. Thorn
(b) Address 808 Cornwall Rd - Lebanon, Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location Lebanon, Penna.

18 (a) Funeral director Wm. J. Tinkertson
(b) Address South & Penna Ave

19 (a) 3-29-1944 (Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 11:31 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraker M.D. Medical Examiner.
Date signed March 29, 1944

G 15373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 a

G 15373 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Giter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Georgia Gites

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1897

8. AGE: Years: 47 | Months: 2 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Richmond Va. (Town, county, and state)

10. Usual Occupation: Junk Dealer

11. Industry or business: "

FATHER
12. Name: Edward Giter Sr.
13. Birthplace: Richmond Va.

MOTHER
14. Maiden Name: Mary Hunt
15. Birthplace: Farmsville Va.

16 (a) Informant: Mary F. Gander
(b) Address: 2131 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 - 22 - 44 (month) (day) (year)
(c) Cemetery or crematory: Leakins Memorial PK
Location: Balto. Md.

18 (a) Funeral director: Crisfield & Gaddes
(b) Address: 2101 McCulloh St Balto Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 22 1944 Huntington Hill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944 at 12 o'c P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 17 1944 to Mar 18 1944 and that I last saw him alive on March 18 1944.

Immediate cause of death: Hypertensive Cardio-Renal disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: G H Banfield M. D.
Address: Provident Hospital Date signed: 3/24/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

70 #35339 G 15374 BALTIMORE CITY HEALTH DEPARTMENT ✓ G 15374
CERTIFICATE OF DEATH 107 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 8 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3727 Gough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Ella Clautice

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1873

8. AGE: Years 70 | Months 6 | Days 18 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name Edward Bell
13. Birthplace Maryland

MOTHER: 14. Maiden Name Kate Dorsey
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23rd 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Ave Ext

18 (a) Funeral director Leo J. Cook
(b) Address 1701-03 N Patt Park Ave

19 MAR 22 1944 (Date rec'd by registrar) Hampton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1944, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1938 to 3-20 19 XX and that I last saw h[e]r alive on 3-20 19 XX.

Immediate cause of death Pneumonia

Duration

Due to

Due to over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathna M. D.
Address B. C. H. Date signed 3-20-44

G 15375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a G 15375 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glen Arm
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Currens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-43

8. AGE: Years | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert C.
13. Birthplace Virginia

MOTHER 14. Maiden Name Lottie
15. Birthplace Virginia

16 (a) Informant Robert C Currens
(b) Address Glen Arm Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Long Green Brethren
Location Glenarm Md.

18 (a) Funeral director Hornberger & Gross
(b) Address Benson Md

19 (a) (b)
(Date received by Registrar) Registrar

VS Form MAR 22 1944 Hunting for Millers, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1944 at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1943 to 3-21 1944, and that I last saw deceased alive on 3-21 1944.

Immediate cause of death Anoxia

Due to Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature W. L. Raffucci M. D.
Address Date signed

15376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15376
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3736 Towanda Ave
(c) Hospital or institution:

15117

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3736 Towanda Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kemick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired Merchant

FATHER
12. Name Abraham D. Kemick
13. Birthplace Russia

MOTHER
14. Maiden Name Lena ?
15. Birthplace Russia

16 (a) Informant Mrs Rose Kemick
(b) Address 3736 Towanda Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem.
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

MAR 22 1944 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1944, at 5. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 15, 1942 to March 21, 1944 and that I last saw h[illegible] alive on March 11, 1944.

Immediate cause of death: Acute Cardiac Decompensation — Duration

Due to: Complete Heart Block

Due to: Arteriosclerotic Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sigmund Goldby M.D.
Address Ellicott City, Md Date signed Mar 22 1944

H L. Wallenweber M.D. assistant medical examiner

15877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

G 15377 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 / 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Gilmor St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1944

8. AGE: Years | Months | Days | If less than one day 4 hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Charlie Jones

13. Birthplace Virginia

MOTHER 14. Maiden Name Annabelle Moye

15. Birthplace Wilmington, N.C.

16 (a) Informant Annabelle Chambers

(b) Address 422 N. Gilmor St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL MAR 2 1944

18 (a) Funeral director Commissioner of Health

(b) Address MAR 22 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1944 at 8 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 22 1944 to Mar. 22 1944 and that I last saw her alive on Mar. 22 1944

Immediate cause of death	Duration
Congenital Syphilis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Rathlin M.D.

Address 426 N. Gilmor St Date signed 3/24/44

VS 180

10812

G 15378 BALTIMORE CITY HEALTH DEPARTMENT G 15378

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3424 Mondawmin Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA BELLE FAIRBANKS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Theodore Fairbanks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1867

8. AGE: Years 77 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: School Teacher

11. Industry or business: retired 37 yrs.

FATHER
12. Name: David Ulysses Thursby
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Henrietta O. Kennard
15. Birthplace: Baltimore, Md.

16 (a) Informant: John Edward Thursby
(b) Address: 104 Midhurst Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: North Ave. & Broadway

MAR 22 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 4:55 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Faulkner M.D. Medical Examiner.
Date signed March 21, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 15379

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 94a

G 15379

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Biddison Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILMER BARNES

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	215-03-3081

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie C. Barnes
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1877

8. AGE: Years	Months	Days	If less than one day
66 5	4	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Pressman - retired
11. Industry or business National Stamping & En.

FATHER
12. Name Joseph Barnes
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Wickens
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Minnie C. Barnes
(b) Address 4009 Biddison Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.
HENRY SANDER & SONS, INC.

18 (a) Funeral director
(b) Address North Ave. & Broadway

19 (a) MAR 22 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1944, at 3 P. M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to Angina Pectoris

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 20 1944

G 15380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15380 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3819 Ridgecroft Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 Ridgecroft Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Woodward

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-0129

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Estella Woodward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1894

8. AGE: Years 49 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Route Foreman

11. Industry or business Standard Oil Co.

FATHER 12. Name Robert J. Woodward

13. Birthplace Va

MOTHER 14. Maiden Name Fannie Harris

15. Birthplace Va.

16 (a) Informant Estella Woodward

(b) Address 3819 Ridgecroft Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave

18 (a) Funeral director Howard N. Bigg Jr.

(b) Address 4914 Belair Road

19 (a) Date received 3 22 1944 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to March 20 1944, and that I last saw alive on March 19 1944.

Immediate cause of death Coronary occlusion — Duration

Due to & Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Pugsley, M.D.
Address 4004 Gaither Road Date signed 3-27-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

G 15381

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Norris (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth R Shilling

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	Widowed

6 (b) Name of husband or wife Elmer Shilling

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 12 1863

8. AGE: Years	Months	Days	If less than one day
51	7	28	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Schaffer Rudolph
13. Birthplace Balto

MOTHER
14. Maiden Name Schiffer
15. Birthplace Balto

16 (a) Informant Mrs D Thomas
(b) Address 1719 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Thos F Kenny
(b) Address Hollins & Gilmor

19 (a) MAR 22 1944 (Date received by local registrar) (b) Huntington Hilliard

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1944 at 6.00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCally M.D. Medical Examiner.
Date signed 3/20/44

G 15382 G 15382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2232 Penrose Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2232 Penrose Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary A Mulroy

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife late John F Mulroy
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 10, 1864

8. AGE: Years	Months	Days	If less than one day
79.	10	11	..... hr. ..... min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

MOTHER / FATHER
12. Name Michael McEvoy.
13. Birthplace Ireland
14. Maiden Name Catherine Graven
15. Birthplace Ireland

16 (a) Informant Mrs Laurence L Lehrer
(b) Address 2232 Penrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director John F Cowan & Son
(b) Address 901-03 W Fallows Street

19 (a) 3-22-1944 (Date rec'd by registrar) (b) Huntingtown Pittsburgh, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st 1944, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1st 1944, to March 21st 1944 and that I last saw h.r. alive on March 20 1944

Impediate cause of death	Duration
Angina Pectoris	4 days
Due to Hypertension	1 yr
Due to Nephritis	
Other Conditions Cardiac Insufficiency	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Thos G Ferrand M. D.
Address 2 W Read St Date signed .....

VS 8

G 15383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

G 15383 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Woodyard (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Connell Grace

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years	Months	Days	If less than one day
6 yrs.			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Fred Grace
13. Birthplace S.C.

MOTHER
14. Maiden Name Zimie Fuller
15. Birthplace S.C.

16 (a) Informant Zimie Grace
(b) Address 1327 Woodyard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Pont Balto.

18 (a) Funeral director Chas H Alexander
(b) Address 927 N Mount St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1944, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1944, to 3/21 1944, and that I last saw h~~im~~ alive on 3/20 1944.

Immediate cause of death: Subacute Bacterial Endocarditis — Duration: 49 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn O. Summerton M. D.
Address 3/21/44 Date signed
University Hospital

G 15384

G 15384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1600

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 102 N. Monastery Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Ebbert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1944

8. AGE: Years	Months	Days	If less than one day
0	0	2	hr min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name Charles Bernard Ebbert

13. Birthplace Balto., Md.

MOTHER

14. Maiden Name Catherine Newell

15. Birthplace Balto., Md.

16 (a) Informant Mrs. Catherine Ebbert

(b) Address 102 N. Monastery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23/44 (month) (day) (year)

(c) Cemetery or crematory St. Peters Cem

Location Baltimore Md

18 (a) Funeral director Fredk. L. Kramer & Son

(b) Address 1416 N. Charles St

19 (a) MAR 22 1944 (Date received by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22, 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1944 to 3/22 1944. and that I last saw him alive on 3/22 1944

Immediate cause of death: Acute Resp. Failure

Due to Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert B. Tunney M. D.

Address Mercy Hosp Date signed 3/23/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 160

G 15385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 15385

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 15

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Cold Spring Nursing Home (If rural give location) 2101 Cold Spring Lane

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Margaret Strzepowski

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Henry

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1865

8. AGE: Years	Months	Days	If less than one day hr.	min.
79				

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name ?

13. Birthplace ?

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Margaret Faby

(b) Address Lapped Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)

(c) Cemetery or crematory Maryland Park

Location .....

18 (a) Funeral director Leonard J Burke

(b) Address 5305 Harford Rd

19 MAR 22 1944 (b) .....

(Date rec'd by registrar) Registrar

Hunting for Pittsville, Md

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1944, to March 20 1944, and that I last saw her alive on March 17 1944.

Immediate cause of death Cerebral hemorrhage

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature M H Cutterman M. D.

Address 2324 Reisterstown Rd Date signed 3/24/44

Please write plainly, with ordinary pen and ink. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

G 15386 Sehman G 15386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4505 Valley View Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Sehman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Elizabeth (Kotte) nee Torney
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 3-22-1888

8. AGE: Years	Months	Days	If less than one day
55	11	29	hr. min.

9. Birthplace Baltimore — Md. (Town, county, and state)
10. Usual Occupation Cutter -
11. Industry or business Md Color Printing Co.

FATHER
12. Name John H. Sehman
13. Birthplace Md

MOTHER
14. Maiden Name Costilla ?
15. Birthplace ?

16 (a) Informant Mrs. Elizabeth Sehman
(b) Address 4505 Valley View Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratarn M.D.
Medical Examiner.
Date signed March 21 1944

G 15387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46H

G 15387 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 Shirley Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Shirley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lilian A. Bramble

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife J. Warren Bramble
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 10-16-1880

8. AGE: Years	Months	Days	If less than one day
63	5	4	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Bevans
13. Birthplace Md

MOTHER
14. Maiden Name Sophia Hederman
15. Birthplace Md.

16 (a) Informant Mrs. Lilian A. Vogt
(b) Address 2917 Shirley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Rucks
(b) Address 530 S Harford Rd.

19 (a) MAR 22 19 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 9 6, M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to March 20 1944 and that I last saw h alive on March 19 1944

Immediate cause of death Retroperitoneal Sarcoma — Duration 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 11-8-44
Major findings of operations: Retroperitoneal Sarcoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Leedy M.D.
Address 5106 Harford Rd. Date signed 3-31-44
M. D.

G 15388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9 3D

G 15388 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MARGARET MURPHY (NEE QUADE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or ~~wife~~ Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1864

8. AGE: Years 79 yrs. | Months 3 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mary Zeller (daughter)
(b) Address 803 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

MAR 22 1944 (Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1944 to March 19 1944, and that I last saw h~~er~~ alive on March 18 19 44

Immediate cause of death
Cerebral salemia
Myocardial degen.

Duration 1 2 yr
2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. G. Jones M.D.
Address 2818 Eutaw Pl. Date signed 3-20-44

Huntington Williams, M.D.

H. G. JONES

G 15389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15389 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw & Walkers
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 old Orchard Rd, Towson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Thomson (MRS. BERTHA THOMSON)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Nelson Thomson

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Nov 14 1864

8. AGE: Years 79 Months 4 Days 7 If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Henry Kuehlert
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Koehler
15. Birthplace Germany

16 (a) Informant Mrs. Smith
(b) Address 412 old Orchard Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 23/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John A. Cuttchell Home
(b) Address 1605 Eutaw Place

MAR 22 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944 at 11 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 19 43 to 3/20 19 44
and that I last saw her alive on 3/20/ 19 44

Immediate cause of death: Terminal Pneumonia — Duration

Due to Arteriosclerotic Gangrene

Due to Arteriosclerotic Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Rafferty M.D.
Address St. Agnes Hosp. Date signed 3/20/44

RAFFUCCI

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15390 G 15390

450822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Monticello (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elanza Hamrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Netta

6 (c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): 2-11-75

8. AGE: Years: 69 | Months: 1 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Fla (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Wm A Hamrick
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Levina J. Rogers
15. Birthplace: S.C.

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/44 (month) (day) (year)
(c) Cemetery or crematory
Location: Monticello Fla

18 (a) Funeral director: John D. Mitchell & Son
(b) Address: 1900 Eutaw Place

19 (a) MAR 23 1944 (Date received by registrar) Huntington Fitzgerald, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 21 1944, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 11 1944, to MAR 21 1944, and that I last saw HIM alive on MAR 21 1944.

Immediate cause of death: Cerebral anoxia — Duration

Due to: Operation - Gastrostomy & Esophagostomy

Due to: Carcinoma Esophagus

Other Conditions: Hypertensive (Include pregnancy within 3 months of death)

Date of operation: 3-20-44

Major findings of operation: Carcinoma of esophagus

of autopsy: Bleeding pleural cavities

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: George Burnett M. D.
Address: Johns Hopkins Hosp Date signed: 3-22-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 15391

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Wilhelm St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Wilhelm St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Terance James Fitzpatrick

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1864

8. AGE: Years	Months	Days	If less than one day
80		2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Fitzpatrick
13. Birthplace Ireland

MOTHER
14. Maiden Name Bitty Fitzpatrick
15. Birthplace Ireland

16 (a) Informant Mrs Brederick Hartmann
(b) Address 2022 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Fitzpatrick & Sons
(b) Address 200 W Lafayette Ave Huntington Station

MAR 22 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th 1944, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1944 to 3/18 1944, and that I last saw him alive on 3/18 1944.

Immediate cause of death: Coronary Thrombosis
Due to: Arterial Sclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Reamer M. D.
Address 2145 W Balto St (Date signed)

G 15392 F-94127 G 15392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Pentatan Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hutman (A) Hutman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1944

8. AGE: Years	Months	Days	If less than one day
			15 hr. 8 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Hutman
13. Birthplace New York City N.Y.

MOTHER
14. Maiden Name Vivian Brook
15. Birthplace Baltimore Md.

16 (a) Informant Vivian Hutman
(b) Address 3505 Pentatan Ave. Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL MAR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 22 1944 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1944 to 1/30 1944 and that I last saw him alive on 1/30 1944

Immediate cause of death Prematurity

Due to Poly hydramnios

Due to Multiple Pregnancy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lowe B Schapiro M. D.
Address 1111 Eutaw Pl Date signed 3/1/44

VS 8

0815

15393 F-94130 G 15393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 15 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Pawhatan ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hutsman (B) Hutsman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30-1944

8. AGE: Years	Months	Days	If less than one day
			15 hr. 10 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Hutsman
13. Birthplace New York City N.Y.

MOTHER
14. Maiden Name Vivian Brown
15. Birthplace Baltimore Md.

16 (a) Informant Vivian Hutsman
(b) Address 3505 Pawhatan ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS HOSPITAL SURGICAL MAR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 22 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

0813

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1944 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1944 to 1/30 1944, and that I last saw him alive on 1/30 1944

Immediate cause of death Prematurity — Duration

Due to Polyhydramnios

Due to Multiple Pregnancy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm B Thompson M. D.
Address 1411 Eutaw Pl Date signed 3/1/44

G 15394

F-92537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G 15394 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 N. Milton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Marie Brent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 9, 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Joseph Brent

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Ethel Thomas

15. Birthplace Baltimore, Maryland

16 (a) Informant Ethel Brent

(b) Address 1823 N. Milton Ave. - 13

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL MAR 21 1944

18 (a) Funeral director Commissioner of

(b) Address

19 (a) MAR 22 1944 (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

VS 3

0814

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1944, at 4:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1944 to Jan 10 1944, and that I last saw her alive on Jan 10 1944.

Immediate cause of death Atelectasis of Lungs. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris L. Ratzkin M. D.

Address Sinai Hospital Date signed

15395
449531

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G 15395
CERTIFICATE OF DEATH 57 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL, and give town)
(d) Street No. Route 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Reed.
3 (b) If veteran, name war
3 (c) Social Security Account No. 203-07-4336

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/8/89
8. AGE: Years 54 Months 11 Days 14 If less than one day hr min.
9. Birthplace md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business
FATHER 12. Name John Reed
15. Birthplace Va -
MOTHER 14. Maiden Name Nellie Duncan
15. Birthplace Va
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Mar 25 Burial (b) Date thereof Mar 25-44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md
18 (a) Funeral director W.E. Falconer
(b) Address New Market Md
19 (a) MAR 23 1944 (b) Huntington Williams M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch - 22 - 1944 at 5 40 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 16 1944 to Mch - 22 1944, and that I last saw him alive on Mch - 22 1944.

Immediate cause of death Brain Tumor
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 2/18/44
Major findings of operation: Cerebellar Exploration
of autopsy:

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John Saunders M. D.
Address Johns Hopkins Hosp Date signed 3/23/44

Correct age in expressing imperfect years, months, days, etc. Please write the causes of death clearly and legibly.

VS 150

15396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 15396
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2843 WEST NORTH AVE
(c) Hospital or institution: NO
(d) Length of stay in hospital or inst. (yrs., mos., or days) NO
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 2843 WEST NORTH AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS JOSEPH LUBY.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1864

8. AGE: Years	Months	Days	If less than one day
80		3	hr. min.

9. Birthplace Ireland (Town, county, and State)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Daniel Luby
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Keating
15. Birthplace Ireland

16 (a) Informant Jos. Doyle
(b) Address 2843 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Gregg & Gurley
(b) Address Fulton Ave & Fayette

19 MAR 23 1944 (Date received by local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 20 1944 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB 28 1944 to MAR 20 1944 and that I last saw h IM alive on MAR 20 1944.

Immediate cause of death	Duration
DIABETUS MELLITIS	1940
Due to CHRONIC MYOCARDITIS	1940
Due to ARTERIOR SCLEROSIS	1940
Other Conditions NONE	

(Include pregnancy within three months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Chas O Chantre M. D.

Address 3013 ST PAUL ST Date signed 3/20/4

Correct age is supremely important — if unknown, please write the causes of death clearly and legibly.

15397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G 15397

Correct age if apparently important. If uncertain, give best estimate. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) [illegible] 21yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3511 Windsor Mill Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jack Lipsey

3 (b) If veteran, name war

3 (c) Social Security Account No. 245-22-2698

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ellen nee Carrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 4 80

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Union, N.C. (town, county and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Lewis Lipsey

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah -

15. Birthplace Russia -

16 (a) Informant Sidney M. Lipsey

(b) Address 701 W. North St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-44 (month) (day) (year)

(c) Cemetery or crematory Balto. Hebrew

Location

18 (a) Funeral director Jacob Levin Sons

(b) Address 1739 E. Baltimore St. Attorney for Petitioner, M.D.

19 MAR 23 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/1944 at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1944 to 3/21 1944 and that I last saw him alive on 3/21 1944.

Immediate cause of death Resp. failure — Duration

Due to Mediastinal Carcinoma (metastatic)

Due to Ca of kidney

Other Conditions Old myocardial infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: [redacted]

of autopsy: Primary kidney Ca Mediastinal Ca. underlying

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Leonard Aksman M. D.

Address Sinai Hosp Date signed 3/21/44

VS 150

45 1028
98

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH 74a

G 15398
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: CARROLL
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. SYKESVILLE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Mellema

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William
6 (c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): 1-24-1916

8. AGE: Years: 28 | Months: 1 | Days: 30 | If less than one day: hr. 28 min.

9. Birthplace: Md
(Town, county, and state)

10. Usual Occupation: ?

11. Industry or business

FATHER
12. Name: FRANK BROTHERS
13. Birthplace: MD

MOTHER
14. Maiden Name: SALLIE SAKER
15. Birthplace: MD.

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 25, 1944 (month) (day) (year)
(c) Cemetery or crematory: Oakland Cem.
Location: Carroll Co., Md.

18 (a) Funeral director: C. Harry Weer
Sykesville, Md.

MAR 23 1944
(Date rec'd by registrar)

19 (a) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 22 1944 at 8:27 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1944 to 3-22 1944
and that I last saw her alive on 3-22 1944.

Immediate cause of death: Chronic Myeloid Leukemia — Duration: 4 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Robert E. Farber, M. D.
Address: Johns Hopkins Hospital Date signed 3/22/44

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G 15399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave
(c) Hospital or institution:
Maryland General Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Elliott W. Darling

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Sarah Darling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1875

8. AGE: Years 68 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Auburn Mass.
(Town, county, and state)

10. Usual Occupation Estimator

11. Industry or business Bethlehem Steel Co

FATHER
12. Name Jasper T. Darling
13. Birthplace Mass

MOTHER
14. Maiden Name Sarah Winchester
15. Birthplace Mass

16 (a) Informant Sarah Darling
(b) Address 114 W. Mulberry St

17 (a) Cremation (b) Date thereof 3/23/44
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Wilson Service
(b) Address 1219 Eutaw St

19 MAR 23 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1944, at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8 1944 to 3-21 1944.
and that I last saw him alive on 3-21 1944.

Immediate cause of death: Heart block — Duration: 4 hrs.

Due to

Due to

Other Conditions Carcinoma of Colon & intestinal obstruction from
(Include pregnancy within 3 months of death)

Date of operation 3-20-44

Major findings of operation: Ca. of colon & intestinal obstruction

Results of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Young Jr. M. D.
Address Md. Gen. Hosp. Date signed 3-24-44

VS 180

Please write plainly; use ink; do not use pencil. Physicians: please write the causes of death clearly and legibly. Any false statement, omission, or concealment of facts called for on this certificate may subject the informant to a penalty for perjury. Cause of death must be entered by a physician, if any such is in attendance during last illness; if not, the coroner must be notified immediately. Do not report "old age" as the cause of death, but state the primary cause, as "cerebral hemorrhage," "pneumonia," etc. "Old age" is the cause of death only in those cases in which no other cause can be assigned. Deaths from violence must be reported to the coroner, whether apparently due to accident, suicide, or homicide. Violent deaths must be reported immediately to the coroner, and no certificate shall be issued until he has investigated the case and authorized the issuance of a certificate

G 15400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G 15400

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 42 S. Bond

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 42 S. Bond (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Annie Watkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Cold

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 39 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER 12. Name Walter Henson

13. Birthplace Md

MOTHER 14. Maiden Name Carrie Webb

15. Birthplace Md

16 (a) Informant Ethel White

(b) Address 103 Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 25-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co. Md

18 (a) Funeral director James A Davis

(b) Address 142 W Pratt St

19 (a) (Date rec'd by registrar) MAR 23 1944 (b) Registrar's signature Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1944, at 8 12 a M

21. I certify that death occurred on the date above stated, that I attended deceased from 1·28 1944 to 3·21 1944 and that I last saw h[illegible] alive on 3·21 1944

Immediate cause of death: Acute myocarditis — Duration: 1 day

Due to Pulmonary edema — 3 days

Due to Lobar Pneumonia — 6 days

Due to La Grippe — 3 weeks

Other Conditions Pulmonary T. B. — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Wm. L. Berry, M. D.

Address 1420 E. Chase Date signed 3·22·44

G 15401

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

G 15401 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5230 Harford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State Md b County
c City or town Baltimore
(If outside city or town limits, write RURAL and give town)
d Street No. 5230 Harford Rd
(If rural give location)
e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward F. Van Reuth, Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Amelia nee Arand | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7-1867

8. AGE: Years	Months	Days	If less than one day
76	11	15	hr min

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Florist
11. Industry or business

FATHER 12. Name Edward F. Van Reuth
13. Birthplace Breda Holland

MOTHER 14. Maiden Name Maria De Swerdt
15. Birthplace Antwerpt Belgium

16 (a) Informant Mrs. Amelia Van Reuth
(b) Address 5230 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 2300 Harford Road

19 (a) (Date received by Registrar) MAR 23 1944 (b) Registrar

For use of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1944, at 8:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941, to Mar 22 1944, and that I last saw h[im] alive on Mar 21 1944

Immediate cause of death: Acute Cardiac Dilatation. — Duration

Due to Arteriosclerosis -

Due to

Other Conditions Senility.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
I underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Boyle.
Address 5217 Harford Rd Date signed 3/22/44
M D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15402
Registered No.

15402

1102

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Low St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Low St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Lucy Cropper
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female Col.
5. Color or race
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Isaiah Cropper
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1886
8. AGE: Years 58 | Months | Days | If less than one day: hr. min
9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Isaiah Cropper
(b) Address: 1104 Low St
17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 3/24/44 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location:
18 (a) Funeral director: Elray C. Wilson
(b) Address: 1000 Brantley ave
19 (a) MAR 23 1944 (b) Hunting tor Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1944 at 3:15 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1944 to 3-20 1944 and that I last saw her alive on 3/20 1944

Immediate cause of death: Pneumonia
Due to: Arteriosclerosis
Due to: Senility
Other Conditions:

Duration: 4 wks / 2 days / 2 days

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury:
23. Signature: Lee R. Blake
Address: 327 N Central Date signed: 3/24/44

VS 150

G 15403

450 352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 15403
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1245 Orleans St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Walter Perkins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 3-26-77

8. AGE: Years 66 | Months 6 | Days 22 | If less than one day: hr min

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation painter
11. Industry or business

FATHER
12. Name Samuel Perkins
13. Birthplace Va.

MOTHER
14. Maiden Name Louise Corbin
15. Birthplace Va.

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23/1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore, National
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date received by local registrar) (b) Huntingtown Md. Registrar

MAR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944 at 9 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 2 1944 to Mar. 18 1944 and that I last saw him alive on Mar. 18 1944.

Immediate cause of death: Respiratory failure — Duration: 2 yrs.
Due to: Arteriosclerosis generalized
Due to: Bronchopneumonia
Other Conditions: Hemiplegia, left
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Graham Corbin
Address T. Hopkins Date signed 3-20 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

15404

BALTIMORE CITY HEALTH DEPARTMENT G 15404 Registered No.

CERTIFICATE OF DEATH 121a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 N. Bentalow St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 N. Bentalow St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward C. Schlingman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	widower

6 (b) Name of husband or wife Kate Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1882

8. AGE: Years	Months	Days	If less than one day: hr.	min
61	7	12		

9. Birthplace Balto., Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business H. B. Taylor Co
FATHER 12. Name Fred C. Schlingman
13. Birthplace Germany
MOTHER 14. Maiden Name Mary Bachman
15. Birthplace Balto., Md
16 (a) Informant Rev Edw. L. Schlingman
(b) Address 35 W. Phila ave Boyertown
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/44
(c) Cemetery or crematory Schwartz
Location 611 S. O'Donnell St.
18 (a) Funeral director Harry H. Leitte
(b) Address 410 Edmondson Ave
19 (a) [illegible] (Date received by registrar) [illegible] Registered [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/44 19 , at 5 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 19 44 to March 20 19 44, and that I last saw h / M alive on March 20 19 44.

Immediate cause of death Coronary Thrombosis — Duration 1 day
Due to Cardio-Renal-~~Hypertension~~ Vascular Disease — 2 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
I underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J N Wilson
Address 617 W. 40th Date signed 3/22/44 M. D.

VS 180

G 15405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15405
Registered No. 112

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 W. Pratt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter N. Enos.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 217-01-9247

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White.	Married.

6 (b) Name of ~~husband~~ or wife Helen M. Enos.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11-1905

8. AGE: Years	Months	Days	If less than one day
38	9.	9.	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Brentwood Taxi Co.

FATHER
12. Name Newton F. Enos.
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Nellie B. Marsh.
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Helen M. Enos
(b) Address 1607 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 24-44. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 505 N. Monroe St.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March, 20, 1944. at 11.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1944 to 3/20 1944. and that I last saw him alive on 3/20 1944.

Immediate cause of death: Acute Dilatation of Stom
Due to: Bronchial Asthma
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 1 day

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas A Enos M. D.
Address 2145 W Balto St Date signed 3/22/44.

15406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15406 Registered No.

1 PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Peterson

3 (b) If veteran, name war None.

3 (c) Social Security Account No. 214-12-8790.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Martha Peterson.

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Oct. 7-1862

8. AGE: Years 81 | Months 5 | Days 13. | If less than one day: hr. min

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual Occupation Contractor and
11. Industry or business Builder.

FATHER
12. Name Elias Peterson
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Margaret Bradley.
15. Birthplace Eastern Shore Md.

16 (a) Informant Mrs Ethel Entriken.
(b) Address 2501 W. Lafayette Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Mar. 23-44. (month, day, year)
(c) Cemetery or crematory Parkwood Cemetery.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwartz.
(b) Address 505 N. Monroe St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 1:25 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ✓, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 20 1944 M.
(b) Where did injury occur? 1300 W. Lexington St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Inhaled illuminating gas

23. Signature Robert L. Graham M.D. Medical Examiner
Date signed March 20 1944

G 15407 ✓ G 15407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Longwood St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore 40 yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
d Street No. 1209 Longwood St
(If rural give location)
e If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Parker M. Dalton

3 (b) If veteran, name war —

3 (c) Social Security Account No. 2120 16 763

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Betsea Dalton
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Nov. 10-1886

8. AGE: Years	Months	Days	If less than one day
57	4	10	hr. min.

9. Birthplace Richmond Va
(Town, county, and state)

10. Usual Occupation Counter man
11. Industry or business Restaurant

FATHER
12. Name Walter Dalton
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Betsea Dalton
(b) Address 1209 N. Longwood St

17 (a) (Burial, cremation, or removal) (b) Date thereof 3rd 23rd 1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem
Location —

18 (a) Funeral director L. E. Jones
(b) Address 111 S. Gilmor st

19 (a) MAR 23 1944 (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20th 1944, at 9 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1943, to March 20 1944, and that I last saw h[illegible] alive on March 2- 1944.

Immediate cause of death	Duration
Coronary occlusion	few hours
Due to Arteriosclerosis	1 yr.
Due to	
Other Conditions	

Include pregnancy within 3 months of death

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3/24/44

6408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 15408
Registered No.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3100 Keswick Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Keswick Road (If Rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country.

3 (a) FULL NAME Mrs. Eddie Mantide Shrieves

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow.

6 (b) Name of husband or wife: John D. Shrieves

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7- 1888

8. AGE: Years 55 | Months 4 | Days 14 | If less than one day: hr min

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mrs. Helen Shaffer
(b) Address: 3100 Keswick Road

17 (a) Burial, cremation, or removal: Burial (b) Date thereof: March 24-1944 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Baltimore Co. Md.

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3231 Fallls Road

MAR 23 1944

(Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21- 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from March 19 1944, to March 21 1944, and that I last saw h Sh alive on March 21 1944.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Diabetes Mellitus	8 yrs
Due to Cardio-renal-Vascular Disease	8 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J N Wilson
Address 617 W. 40th St Date signed 3/22/44 M. D.

15409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G 15409

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 E. 28th St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Scott
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: black
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)
8. AGE: Years: 37 Months: Days: If less than one day: hr min
9. Birthplace: Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William Reed
13. Birthplace

MOTHER
14. Maiden Name: Emma Long
15. Birthplace

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 14 44 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary Cem
Location: A, Q. Co Md

18 (a) Funeral director: Mrs Ida Bailey
(b) Address: 142 Jefferson St

19 MAR 23 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 20 1944 at 6.00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from MAR. 20 1944, to MAR. 20 1944, and that I last saw HER alive on MAR. 20 1944.

Immediate cause of death: SUBARACHNOID HEMORRHAGE — Duration:

Due to: ESSENTIAL HYPERTENSION

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H. Slaughter M. D.
Address: Johns Hopkins Hosp Date signed 3/21/44

G 15410

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46F

G 15410

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Dickerson French

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Joseph S.
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 14, 1894
8. AGE: Years 50 - 1894 Months 2 Days 5 If less than one day hr. min.
9. Birthplace St. Louis, Mo. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Henry T. Dickerson
13. Birthplace Kentucky
14. Maiden Name Mary A. Goulding
15. Birthplace Kentucky

16 (a) Informant Mrs. Laura Beatty
(b) Address 1230 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-44 (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Mrs. Ed. H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Lington Williams, M.D. Registrar

MAR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944 at 7.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1944. to March 19 1944 and that I last saw her alive on March 19 1944.

Immediate cause of death
Carcinoma of Liver — Duration ? 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Beatty M. D.
Address 230 Druid Hill Ave Date signed 3/23/44

G 15411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 15411
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 Goldsheet
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - (7)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Gold
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Mildred Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1909

8. AGE: Years 34 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William A. Brown
13. Birthplace Virginia

MOTHER
14. Maiden Name Christiana Abrams
15. Birthplace Maryland - (Chesapeake)

16 (a) Informant Mr. Dorothy McDonald (Sister)
(b) Address 1602 May Ct - Fredonia Proj.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS MAR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1944, at 1630 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1944 to 3/20 1944 and that I last saw h[er] alive on 3/20 1944.

Immediate cause of death Lobar Pneumonia

Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carson C. Johnson
Address 1802 Penna Ave Date signed M. 3/24/44 D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15412 ✓ G 15412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 16

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County —
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Riggs Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME C. EDWARD JONES, SR.

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Josephine E. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
69	1	6		

9. Birthplace Balto. Maryland (Town, county and state)
10. Usual Occupation Printer - Sub-Foreman
11. Industry or business U. S. Gov't. Printing Office

FATHER
12. Name Lawrence E. Jones
13. Birthplace St. Michaels Md.

MOTHER
14. Maiden Name Mary Jane Jamison
15. Birthplace Balto. Maryland

16 (a) Informant Mrs. Alma C. Griffith
(b) Address 2910 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 22 1044 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1944, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1944 to 3/22 1944, and that I last saw him alive on 3/22 1944.

Immediate cause of death Cardio - Respiratory failure. — Duration

Due to Coronary Thrombosis

Due to Congestive Heart Failure

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. McCadden M. D.
Address Mercy Hospital Date signed 3/22/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15413
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 Garrison Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE PHILIP BARTGIS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Margaret E. Bartgis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 13, 1862

8. AGE: Years: 81 | Months: 7 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Frederick, Md.
(Town, county, and state)

10. Usual Occupation: --
11. Industry or business:

FATHER
12. Name: George W. Bartgis
13. Birthplace: Md.

MOTHER
14. Maiden Name: Sophia E. Ertner
15. Birthplace: Md.

16 (a) Informant: Mr. Charles P. Bartgis
(b) Address: 11 N. Summit Ave., Chatham, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. GICKNER & SONS
Address: 1017 Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22, 1944 at 4:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from , 19 , to , 19 , and that I last saw h / M alive on Mar 22 19 44.

Immediate cause of death: Coronary arteriosclerosis about — Duration: 5 mo
Due to advanced arteriosclerosis ?
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Wirth M. D.
Address 2220 Garrison Blvd Date signed 9/23/44

PLEASE WRITE PLAINLY. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15414

Registered No. 94a

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALTON F. THOMPSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
--	no	Male	White	Married

6 (b) Name of husband or wife Queenie M. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/31/1890

8. AGE: Years	Months	Days	If less than one day
53	4	21	hr. min.

9. Birthplace Charles Co., Md. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Balto. Fire Dept.

FATHER
12. Name Millard Thompson
13. Birthplace Md. Huntington / Williams, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

MAR 23 1944

16 (a) Informant Mrs. Queenie M. Thompson
(b) Address 2006 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180 Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22, 1944, at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15, 1944, to Mar. 22, 1944, and that I last saw him alive on Mar. 22, 1944.

Immediate cause of death	Duration
Coronary Thrombosis	7 days
Due to Coronary Arteriosclerosis	3 years
Due to ✓	
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Frank N. Ogden, M. D.
Address 2701 N. Calvert St. Date signed May 22, 44

443166 15415

G 15415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 24a

Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Be sure that age is correct.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7/24

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1110 Wood Heights Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lynn HART (Lynn Elizabeth Hart)

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-9-43

8. AGE: Years	Months	Days	If less than one day
	10	13	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name George A. Hart

13. Birthplace Md. (Cross, Dorchester Co.)

MOTHER 14. Maiden Name Lillian Hawkins

15. Birthplace Palmyra N.J.

16 (a) Informant Richard

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address Balto. & Williams, Md.

19 (a) MAR 23 1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1944, at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1943 to 3-22 1944, and that I last saw h[illegible] alive on 3-22 1944.

Immediate cause of death Respiratory failure

Due to Staphylococcus Septicemia

Due to

Other Conditions Cardiac failure (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul E. Wilson M. D.

Address Johns Hopkins Hosp. Date signed 3-22-44

G 15416 BALTIMORE CITY HEALTH DEPARTMENT G 15416

CERTIFICATE OF DEATH 47 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 11/29/43
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 McElderry Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD WINDELL RODEN

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No. 376-104-24

4. Sex: Male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marion Roden Phew-(Single name)
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1891

8. AGE: Years 53 | Months 2 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffeur -4 yrs. ago
11. Industry or business

FATHER
12. Name James Roden
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Baltimore, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-1944 (month) (day) (year)
(c) Cemetery or crematory Balto National Cem
Location Dundalk Ave Balto Md

18 (a) Funeral director Byron Flemming & Knight
(b) Address 725 Pasquito St

19 (a) MAR 23 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 19, 1944, at 2:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29, 1943 to Mar. 19, 1944, and that I last saw him alive on Mar. 19, 1944.

Immediate cause of death: Bronchogenic carcinoma of the left lung with metastasis to the brain. — Duration: Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Johnson M. D.
Address Baltimore Md. Date signed 3/20/44

Va-14078

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15417 G 15417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 95C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 N Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 N Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Morgan

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Victoria Morgan

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jan 25th 1874

8. AGE: Years	Months	Days	If less than one day
70	1	24	hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Henry Morgan
13. Birthplace Md
14. Maiden Name Louisa ?
15. Birthplace Md

16 (a) Informant Victoria Morgan
(b) Address 1804 N Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto, Md

18 (a) Funeral director Belfront Mamie H. Wright
(b) Address 72 Pelsquith St,

19 (a) ... (b) ...
(Date rec'd by registrar) Registrar

MAR 20 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1944, at 4P M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 21 1944 to Mch 19 1944, and that I last saw him alive on Mch 19 1944.

Immediate cause of death Organic Heart Disease — Duration Hours, days, or months

Due to ...

Due to ...

Other Conditions Bronchitis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Garland Ashwell, M.D.
Address 1534 Eutaw Pl Date signed Mch 21

Physicians: please write the causes of death clearly and legibly. Please write correct age in years. Please write correct age is especially important.

G 15418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15418 Registered No. 1210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1829 Covington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 Covington St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Katie Appel Marshall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1863

8. AGE: Years	Months	Days	If less than one day
80	9	11	hr. min.

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B & O RR.

FATHER
12. Name Alexander Marshall
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa Cecil
15. Birthplace Maryland.

16 (a) Informant Elmer E. Marshall
(b) Address 783 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. End of North Ave

18 (a) Funeral director William M. Mauck
(b) Address 715 Light St.

19 (a) MAR 23 1944 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22nd 1944, at 11.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1/44 19 Mch. 22/44. 19, and that I last saw h.im alive on Mch. 20/44.

Immediate cause of death — Duration

Chronic Paranchymatous Nephritis. Unknown.

Due to

Due to

Other Conditions Arterio-Sclerosis. Unknown.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Lewis Clemens M. D.
Address 933 Hanover Date signed Mch. 23/44.

G 15419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15419 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkins Ave

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Caton & Wilkins Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sister Dorella Mc Kenzie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1872

8. AGE: Years	Months	Days	If less than one day
71	11	12	hr. min.

9. Birthplace St. Louis Mo. (Town, county and state)

10. Usual Occupation Sister of Charity

11. Industry or business

FATHER 12. Name William Mc Kenzie

13. Birthplace Mo

MOTHER 14. Maiden Name Ellen O'Neill

15. Birthplace Mo

16 (a) Informant St. Agnes Hospital

(b) Address Caton + Wilkins Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md.

18 (a) Funeral director Martin Gahagan

(b) Address 1827 N. North Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MAR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 19 44 at 9 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1943 to 3/21 1944, and that I last saw h[illegible] alive on 3/18 19 44

Immediate cause of death Arterio sclerotic C-V-D

Duration

Due to

Due to

Other Conditions Cachexia Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)

(e) Means of injury

23. Signature Sister Rosalia

Address St Agnes Hosp Date signed 3/23/44 M.D.

G 15420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G 15420 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 E. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 94 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Clarke Harris

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Nr.	None	Male	White	

6 (b) Name of husband or wife Annie Patterson 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1849

8. AGE: Years	Months	Days	If less than one day: hr.	min.
94	8	3		

9. Birthplace Granville Co. N. Carolina (Town, county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Dr Adam Clarke Harris
13. Birthplace Granville, N. C.

MOTHER
14. Maiden Name Annie Patterson
15. Birthplace Millsborough, Tennessee

16 (a) Informant Mrs Wagner
(b) Address 317 E. N. Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3 24 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director D. J. Corning Co.
(b) Address 21 W 25 St.

19 (a) (Date rec'd by Registrar) (b) Registrar
MAR 23 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23 1944, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940, to March 23 1944, and that I last saw h alive on 19

Immediate cause of death Cancer of face — Duration 3 mos.
Due to
Due to
Other Conditions Senility.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh Forsythe, M. D.
Address 422 E. North Ave. Date signed 3-23-'44

G 15421

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15421
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Burgundy Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1888

8. AGE: Years 55 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Henry Brown
13. Birthplace Va

MOTHER
14. Maiden Name Mary Bush
15. Birthplace Va

16 (a) Informant Mrs Mary Sidney
(b) Address 623 N Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City, Md.

18 (a) Funeral director Joseph A. Lively
(b) Address 410 N Mount Street,

19 (a) (Date rec'd by registrar) (b) Ivan Williams, M.D. Registrar

P 28394

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1944; at 5:?? M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis.
Acute pulmonary edema.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Welsh M.D.
Medical Examiner.
Date signed 3-21-44

G 15422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1218

Reg. No. G 15422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street & Calvert Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Raye Rosenberg
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Jewish	M

6 (b) Name of husband or wife Mr. Joseph Rosenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 25 Dec 1907

8. AGE: Years	Months	Days	If less than one day hr.	min.
36	2	28		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Max Rabinovitz
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant Husband
(b) Address 2200 E. Baltimore St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Mar 24/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cemt
Location Bowley Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 23 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 March 19 44 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Feb 1944 to 23 Mar 1944, and that I last saw her alive on 23 Mar 1944.

Immediate cause of death Cardio respiratory failure Anemia — Duration

Due to Chronic glomerulo-nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theo J Van Dill III M. D.
Address Union Memorial Hosp Date signed 3-23-44

15423 G 15423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 N. High St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 D
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 N High St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Jefferies

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years	Months	Days	If less than one day
			14 hr. ..... min.

9. Birthplace ..... (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 (a) MAR 23 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1944, at 11:25 A M

21. I certify that I took charge of the remains described above, held an Inquiry - Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Prematurity - (6 mo)

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? —
(d) Means of injury .....

23. Signature Hunter J. Carbonell M.D.
Medical Examiner
Date signed 3/22/44

MAR 2 1944
Commissioner of Health

0818

G 15424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 15424 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1840 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Carey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years 21 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 23 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1944, at 1:15 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 9, 1944

9819

15425

JL - 74942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 15425
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 8 - 17
(e) Length of stay in Baltimore (yrs., mos., or days) 57 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Eutaw Place. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John McIlroy or John McElroy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1852

8. AGE: Years	Months	Days	If less than one day
92	1	23	hr min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Thomas McIlroy
13. Birthplace Iceland

MOTHER
14. Maiden Name Elizabeth Pichard
15. Birthplace Canada

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem
Baltimore [illegible] MAR 23 1944

18 (a) Funeral director [illegible]
(b) Address 2024 O'Keane Av.

19 MAR 23 1944 (Date rec'd by reg.) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 13 19 44 at 4:09 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 - 26 19 42 to 3 - 0 19 44.
and that I last saw him alive on 3 - 13 19 44.

Immediate cause of death
Pneumonia — Duration ?
Due to Senescence — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathena M. D.
Address B. C. H. Date signed 3/24/44

VS 184

0817

Please write plainly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G 15426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15426 Registered No. 1270

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 S London Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and name of town)
(d) Street No. 3702 Old Frederick Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J Griffin

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8 1870

8. AGE: Years	Months	Days	If less than one day
73	3	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Michael Griffin
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Eaton
15. Birthplace England

16 (a) Informant Paul J Griffin
(b) Address 110 S London Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Joseph Stanley Fulton & Fayette Sts
(b) Address

19 (a) (Date rec'd by registrar) MAR 23 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1944 at 3:17 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1944 to Mar 22 1944, and that I last saw him alive on Mar 20 1944.

Immediate cause of death
UREMIA — Duration 1 WEEK

Due to URINARY EXTRAVASATION

Due to POST PROSTATECTOMY

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation FEB. 23, 1944
Major findings of operation:
PROSTATIC HYPERTROPHY
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis P. J. Gallen M. D.
Address 1800 N. Charles St. Date signed 3/23/44

G 15427

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15427
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3106 Abell Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Abell Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Bertie Hall Knighton

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William Thomas Knighton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 22, 1861

8. AGE: Years	Months	Days	If less than one day
82	6	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George H. M. Hall
13. Birthplace Somerset County, Md.

MOTHER
14. Maiden Name Anna Hurtt
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Silas B. Hall
(b) Address 3106 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director Silas L. Amoss
(b) Address 3106 N. Baltimore St. Huntingdon Williams, M.D.

MAR 23 1944

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23 1944 at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10 1944 to Mar 23 1944, and that I last saw her alive on Mar 23 1944.

Immediate cause of death	Duration
Cardiac Dilatation	20 da
Due to Chr. Myocarditis.	2 yrs.
Due to	
Other Conditions old age.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Levi C. Wade M. D.
Address Med. Arts Bldg Date signed

VS 3

correctness is especially important. Physicians: please write the cause of death clearly and legibly.

G 15428 BALTIMORE CITY HEALTH DEPARTMENT G 15428

CERTIFICATE OF DEATH

Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2339 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Ethel Chambers~~ Ethel T. Hughes Chambers

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William C. Chambers
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) September 9, 1890

8. AGE: Years	Months	Days	If less than one day
53	6	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alfred Hughes
13. Birthplace Virginia

MOTHER
14. Maiden Name Violet Ring
15. Birthplace Relay, Md.

16 (a) Informant Mr. William C. Chambers
(b) Address 2339 Edmondson Ave.

17 (a) Burial (b) Date thereof March 25, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 1005 W. Baltimore St.

19 (a) 1944 (b) [illegible] Baltimore, Maryland
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1944 at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 44 to March 22 1944, and that I last saw h e r alive on March 22 44.

Immediate cause of death Terminal Abscess — Duration

Due to Cardiac Embolism — Duration

Due to — Duration

Other Conditions Coronary sclerosis — Duration
(Include pregnancy within 3 months of death)

Date of operation
~~Major findings of autopsy~~ Autopsy Terminal abscess - pyaemic abscess
of autopsy Coronary sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard W. Baetjer M.D.
Address West Baltimore General Hospital Date signed March 22, 44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G 15429

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 N. Durham St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alma Toles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W.

6 (b) Name of husband or wife John Toles
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1907

8. AGE: Years	Months	Days	If less than one day
37	-	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Charles T. Travers
13. Birthplace Balto. - Md.

MOTHER
14. Maiden Name Alice Hawkins
15. Birthplace Va.

16 (a) Informant Lillian Johnson
(b) Address 204 N. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wallace
(b) Address 1000 Bradley Ave

19 (a) [illegible] Washington Williams, M.D. Registrar

MAR 29 1944

VS 180

3/18/44

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 18 - 1944, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 3-18-1944 and that I last saw her alive on 3-17-1944.

Immediate cause of death Cardiorespiratory disease — **Duration**

Due to

Due to

Other Conditions Bronchial asthma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

R. W. Purcell M. D.
Address 1422 E. Oliver Date signed 3-21-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Ossie Goad

G 15430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1406

G 15430 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ossie Goad

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26 1922

8. AGE: Years	Months	Days	If less than one day
21	6	5	hr. min.

9. Birthplace Montgomery Co. (Town, county, and state)
10. Usual Occupation Salesgirl
11. Industry or business Montgomery Ward Co

FATHER
12. Name Lee Goad
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Mary E. Huff
15. Birthplace Carroll Co.

16 (a) Informant Parents
(b) Address Poplar Hill Va.

17 (a) Removed (Burial, cremation, or removal) (b) Date thereof 3-26-44 (month) (day) (year)
(c) Cemetery or crematory Thorn Spring
Location Pulaski Co. Va

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

AVS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944, at 6:10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Generalized peritonitis

Due to Self-induced abortion

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 23, 1944

15431

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

172

G 15431
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2514
(c) Hospital or institution:
Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aubrey L Ellis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rentia Ellis

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1914

8. AGE: Years 29 30 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Regmt
11. Industry or business Shipbuilding

FATHER
12. Name Robt Ellis
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16. (a) Informant Mrs Rentia Ellis
(b) Address 2914 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/44 (month) (day) (year)
(c) Cemetery or crematory Roanoke Va
Location Roanoke Va

18 (a) Funeral director Thos J Kenny
(b) Address Holland & Gilmore

19 (a) MAR 24 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1944, at 9:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspections thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 22, 1944 7:30 P.M.
(b) Where did injury occur? Bethlehem Shipbldg
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell 50' Ship

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 3-23-44

VS 151

G 15432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 330

G 15432
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. City
(b) Street address 541 Bank St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-2
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 541 Bank St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Leon Hearn

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 04 | Months — | Days — | If less than one day hr. — min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Lunch room

11. Industry or business Cook

MOTHER / FATHER

12. Name John H. Hearn

13. Birthplace Delaware

14. Maiden Name Maggie Price

15. Birthplace Md.

16 (a) Informant John H. Hearn
(b) Address Maryland

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemty
Location Balto. Md.

18 (a) Funeral director Walter B. Jones
(b) Address 139 W. Hamburg Street.

MAR 24 1944 Huntingtown Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-1944, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5-1944, to 3-19-1944, and that I last saw him alive on 3-19-1944.

Immediate cause of death Pneumonia (Lobar)

Duration 2 weeks

Due to

Due to

Other Conditions Influenza

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James C Carper M. D.
Address 1016 E. Sharp St Date signed 3-22-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

15433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 15433

AD-84700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 W. Hill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pickens Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15-1888

8. AGE: Years	Months	Days	If less than one day
55	10	4	hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Ruben Allen
13. Birthplace S.C.

MOTHER
14. Maiden Name Partren ?
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calary Cemty
Location Balto.

18 (a) Funeral director Walter B. Price & S
(b) Address 139 W. Hamburg Street

MAR 24 1944 Huntington Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1944 at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1943 to 3/19 1944. and that I last saw h[illegible] alive on 3/19 1944.

Immediate cause of death
Pneumonia

Due to Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Yes & None

Duration
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mathus M. D.
Address B.C.H. Date signed 3/24/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G 15434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

✓ G 15434 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 Shields Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh Hamm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1916

8. AGE: Years	Months	Days	If less than one day hr	min.
28				

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Hamm
13. Birthplace N. C.

MOTHER
14. Maiden Name Nelly Hamilton
15. Birthplace N. C.

16 (a) Informant Margie Hamm
(b) Address 1130 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR 25 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAR 24 1944 (Date received by Registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 17, 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Leukemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 18, 1944

5435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 15435

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2413 Barclay St.
(c) Hospital or institution: 1209
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Emery Horner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Eva Reed Horner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14th 1873

8. AGE: Years	Months	Days	If less than one day hr.	min.
71	0	9		

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Retired Division Manager
11. Industry or business B. & O. R. R.

FATHER
12. Name Edward Horner
13. Birthplace W. Va.

MOTHER
14. Maiden Name Matilda Harvey
15. Birthplace W. Va.

16 (a) Informant Edwin O. Horner
(b) Address Spring Grove Hospital Catonsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Wm Cook Jr.
(b) Address 1212 St Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23rd 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 22nd, 19 44 to Mar. 23rd, 19 44
and that I last saw h alive on 19

Immediate cause of death Coronary Occlusion — Duration 13 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo W Harrington III M.D.
Address 401 E. 25th. St. Date signed 3/24/44.

VS 160

For P. C. J. Lubinski, by Howard J. Anderson, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15436

G 15436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No.

AB-82998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 26-12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos-20days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. No Home (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Walter E. Modzelewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 210-31-0164

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Zoffie (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17-1870

8. AGE: Years	Months	Days	If less than one day
73	4	5 6	hr min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name Joe Modzelewski

13. Birthplace Poland

MOTHER

14. Maiden Name Zoffie Golski

15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 E. Paul St

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1944 and 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1943 to 3-23 1944 and that I last saw h/ alive on 3-23 1944.

Immediate cause of death: Carcinoma of stomach with Metastases — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)

(e) Means of injury

23. Signature Paul Medrne M. D.

Address 13 E. 11 St. Date signed 3-23-44

15437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G 15437
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 Aisquith St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 13 years

2. USUAL RESIDENCE OF DECEASED:
a) State Md b) County
c) City or town Balto
(If outside city or town limits, write RURAL and give town)
d) Street No. 1604 Aisquith St
(If rural give location)
e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Xavier Clarke

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 210-16-8710

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband or~~ wife: Mary C. Clarke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 30 1883

8. AGE: Years: 60 | Months: 8 | Days: 23 | If less than one day: hr min

9. Birthplace: Harford Co. Md.
(Town, county, and state)
10. Usual Occupation: Retired Engineer
11. Industry or business: Insp. Q

FATHER
12. Name: John Blake
13. Birthplace: Md.

MOTHER
14. Maiden Name: Martha O'Donnell
15. Birthplace: Pa.

16 (a) Informant: Mary C. Blake
(b) Address: 1604 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)
(c) Cemetery, or crematory: St. Johns
Location: Long Green, Md.

18 (a) Funeral director: William Cox Inc
(b) Address: 121 S. Paca St

19 MAR 24 1944 Huntington Williamsport
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943, to March 23 1944, and that I last saw h~~im~~ alive on March 17 1944.

Immediate cause of death: Carcinoma of colon — Duration: 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Oct. 1943
Major findings of operation: Inoperable carcinoma of descending colon
of autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Krenger
Address 1402 E. Lanvale St Date signed 3-23-44 (M. D.)

15468 ✓ G 15438

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2631 Dulaney St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5

(e) Length of stay in Baltimore (yrs., mos., or days) 23 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town [illegible] (If outside city or town limits, write RURAL and give town)

(d) Street No. 2631 Dulaney St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Harris J. Poole

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 218-39-5162

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Hazel Poole

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 23rd 1898

8. AGE: Years 45 | Months 9 | Days 0 | If less than one day: hr. ..... min. .....

9. Birthplace Carroll Co. Md (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business McNamara Co

FATHER 12. Name Frank Poole

13. Birthplace Md.

MOTHER 14. Maiden Name Emma Smart

15. Birthplace Md.

16 (a) Informant Hazel Poole

(b) Address 2631 Dulaney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-44 (month) (day) (year)

(c) Cemetery or crematory Poplar Grove

Location Md.

18 (a) Funeral director William Cole & Sons

(b) Address 122 E. Read St.

19 (a) MAR 24 1944 (b) Huntington Williams (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27th 1944, at ..... M

21. I certify that death occurred on the date above stated, that I attended deceased from Mar 17 1944 to 3-30-44 and that I last saw him alive on 3-27-1944

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis.

Due to Bronchitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration: Years ..... Months ..... Days ..... Hours ..... Minutes .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury .....

23. Signature Wm Johnson

Address 422 Edmondson Ave Date signed 3-27-44

WALTER SOWERS - 4012 EDMONDSON

15439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1332

G 15439
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Wolfe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adcock, Margaret M.

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Douglas C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 20 1914

8. AGE: Years	Months	Days	If less than one day hr.	min.
29	3	2		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Venker
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaret Brauer
15. Birthplace Baltimore, Maryland

16 (a) Informant Barbara Desell
(b) Address 23 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul Street

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 24 1944

VS 100

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1944 to 3/22 1944, and that I last saw her alive on 3/22 1944.

	Duration
Immediate cause of death. unknown	
Due to unknown	
Due to unknown	
Other Conditions bilateral hydronephrosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations: —
of autopsy: organs sent to toxicologist

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Schelin M. D.
Address Date signed

G 15440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

G 15440 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3022 Hartford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Hartford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leo Hamburger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Bernhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta
15. Birthplace Germany

16 (a) Informant Ruben David
(b) Address 3022 Hartford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belair Rd.

18 (a) Funeral director Jos. Levy Sons
(b) Address 1439 E. Baltimore St.

19 (a) (Date rec'd by registrar) MAR 24 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1944, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxia by strangulation (Hanging)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature Hunter P. Sullivan M.D. Medical Examiner.
Date signed 3/22/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G 15441 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 3527 DENNISON RD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. MD. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3527 DENNISON RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LYNORA LEVY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife IRVING

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 23 | Months | Days | If less than one day hr. min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name CHARLES M. MISSLER

13. Birthplace RUSSIA

MOTHER 14. Maiden Name BESSIE

15. Birthplace BALTO. MD

16 (a) Informant FATHER

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)

(c) Cemetery or crematory HEBREW FRIENDSHIP
Location BALTO + CONKLIN ST

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) (Date rec'd by Registrar) (b) (Registrar)

MAR 24 1944

VS 100

Huntington Woods, Mich.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22-44 19 at 8:33 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Mar 23 1944 and that I last saw her alive on Mar 23 1944.

Immediate cause of death chronic nephritis.

Duration 15 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address 1124 Eutaw St Date signed 3/25/44

G 15442

JO #34728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G 15442
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2851 Prospect St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Saffell

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John (C)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1887

8. AGE: Years	Months	Days	If less than one day
57	2	6	hr min

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Klaus
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Libno
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem. Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date of [illegible] MAR 24 1944 (b) Registrar for Williams MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1944, at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1943. to 3-21 1944.
and that I last saw h[illegible] alive on 3-21 1944.

Immediate cause of death: Cardiac decompensation — Duration ?
Due to: Hypertensive arteriosclerotic heart disease — Duration ?
Due to: Pneumonia — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Habbe M. D.
Address B.C.H. Date signed 3/21/44

15443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15443

Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison St. & Linden Ave

(c) Hospital or institution: Maryland General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d

(e) Length of stay in Baltimore (yrs., mos., or days) 30 13 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 906 Whitelock St #17 (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Mrs. Freda Dessen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-7-64

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name –

13. Birthplace Russia

MOTHER

14. Maiden Name –

15. Birthplace Russia

16 (a) Informant H. N. Schwartz

(b) Address 1721 Eutaw Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt. Carmel

Location .....

18 (a) Funeral director Jos. Levin Inc

(b) Address 1439 E. Balto. St

19 (a) 4-1944 (Date received by registrar) (b) ..... (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1944 at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1944, to 3/23 1944, and that I last saw her alive on 3-23 1944.

Immediate cause of death Respiratory Failure

Due to Senility

Due to Fracture of lt. st. femur

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: .....

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 3-2-44 at noon P.M.

(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No

(e) Means of injury Fell from a chair

23. Signature Jordan Obermayer M. D.

Address Md. Gen. Hosp Date signed 3/23/44

For D.R.L. Bosbaum by Horace J. Wolcott M.D.

G 15444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15444 / 46D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2117 Dennison

(c) Hospital or institution: Crawford Retreat 157

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County A. A.

(c) City or town Brooklyn Pk. (If outside city or town limits, write RURAL and give town)

(d) Street No. 107 - 4th Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia C. Englar

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1879

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64	7	3		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Thomas Cairnes

13. Birthplace Md.

MOTHER — 14. Maiden Name -- Merryman

15. Birthplace Md.

16 (a) Informant Mr. James B. Englar

(b) Address 107 - 4th Ave., Brooklyn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22-1944, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Mch 22 1944 and that I last saw h[illegible] alive on Mch 22 1944

Immediate cause of death Bronchial Pneumonia — Duration 2 dys

Due to General Carcinomatosis — Duration 18 Mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature P. L. Jepsen M. D.

Address Dulaney Valley Rd. Date signed 3-27

G 15445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15445 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 4103 Westchester Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Westchester Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN WEBB ROLLE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Georgianna E. Rolle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1859

8. AGE: Years 84 | Months 9 | Days 22 | If less than one day: hr. min.

9. Birthplace Trappe, Md. (Town, county, and state)
10. Usual Occupation Carpenter (retired)
11. Industry or business

FATHER
12. Name Fiddeman F. Rolle
13. Birthplace Ky.

MOTHER
14. Maiden Name Ann Eliza Webb
15. Birthplace Maryland

16 (a) Informant Mr. Maurice J. Keese
(b) Address 4103 Westchester Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 24 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Mar. 23, 1944, at 12:30M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1944 to Mar. 23 1944, and that I last saw h[illegible] alive on Mar. 22 1944.

Immediate cause of death Myo-cardiitis — Duration about 2 mo.

Due to Advanced arteria-sclerosis — Duration ?

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles D Zublett, M.D.
Address 2280 Fremont Ave Balto Md. Date signed Mar 24 - 44

G 15446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15446 / 1243 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 + 3
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W. DAVIS

3 (b) If veteran, name war --
3 (c) Social Security Account No. no

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie L. Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/1869

8. AGE: Years 74 | Months 11 | Days 12 | If less than one day: hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Thomas Davis
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Sarah E. Jones
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Bessie L. Davis
(b) Address 1119 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location Harford Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) MAR 24 1944 (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/ 19 44 at 7:25A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3, 1944 to Mar 23 1944 and that I last saw h[illegible] alive on Mar 22 19 44.

Immediate cause of death: Cerebral Thrombosis.
Due to
Due to
Other Conditions: Bilateral Hydro - Static Pneumothorax
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Geo. E. Shannon M.D.
Address 820 Medical Arts Bldg. Date signed 3/23/44

Huntington [illegible]

G 15447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G 15447
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 744 1/2 Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 744 1/2 Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lora Greenleaf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1889

8. AGE: Years	Months	Days	If less than one day
54	7		hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Nelson Russ
13. Birthplace N.C.

MOTHER
14. Maiden Name Lora Russ
15. Birthplace N.C.

16 (a) Informant Russell Coates
(b) Address 744 1/2 N. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date received by registrar) (b) Huntington T. Registrar

MAY 24 1944
VS 169

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1944 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1944 to 5/21 1944
and that I last saw h alive on 19
Immediate cause of death Cerebral hemorrhage

Duration 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify other place)
(e) Means of injury
23. Signature H Hoover M. D.
Address 253 Dolphin St Date signed 5/27/44

G 15448

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 94a

G 15448
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution:
Mercy Hospital H-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d. 0 h.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Arundel Rd. Rimlea Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HUGH W. WHITEHURST

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Bertha Whitehurst

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1878

8. AGE: Years 65 | Months 5 | Days 19 | If less than one day ____ hr. ____ min

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self

FATHER
12. Name Edward Whitehurst
13. Birthplace Texas

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Bertha Whitehurst
(b) Address Arundel Rd., Rimlea Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Wilson Conley
(b) Address 1347 Park Ave.

19 (a) MAR 24 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 19 44, at 3:45 M.

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 3-22-44

15449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15449

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Sanford Pl.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Sanford Pl. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Laura C. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	W. Dow

6 (b) Name of husband or wife James D. Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July ? 1870

8. AGE: Years	Months	Days	If less than one day
63	8		hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Frank Smith
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Jackson
15. Birthplace Md

16 (a) Informant Alberta Taylor
(b) Address 507 Sanford Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/37 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Md

18 (a) Funeral director Hugh S. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by reg.) (b) Attestation for Registrar

MAR 24 1937

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 1937, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1936 to Mar 22 1937 and that I last saw h alive on Mar 21 1937.

Immediate cause of death
Cardio Vascular Disease — Duration 6 mos.
Due to D. of Nerv Compensation — 8 mos.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. William Tay
Address 507 Pa Ave Date signed 3/24/37 M. D.

G 15450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 15450 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Lane
(c) Hospital or institution:
(d) Length of stay in ~~hospital or~~ inst. (yrs., mos., or days) 6 9-1 Wks
(e) Length of stay in Baltimore (yrs., mos., or days) About 81 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3955 Greenmount Avenue (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Catherine M. Sheubrooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thomas J. Sheubrooks
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------

8. AGE: Years	Months	Days	If less than one day
About 81	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Joseph Green
13. Birthplace Not obtainable

MOTHER
14. Maiden Name Catherine Lighthauser
15. Birthplace Not obtainable

16 (a) Informant Miss Bessie Sheubrooks
(b) Address 3955 Greenmount Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) MAR 24 1944 (Month, day, and year) Hunting for Williams (Registrar) M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944 at 2.30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Febr 12 1944 to Mar 23 1944 and that I last saw her alive on Mar. 22 1944.

Immediate cause of death: Carcinoma of breast — Duration: 2 Yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer U. Todd M. D.
Address 735 N. Fulton Ave Date signed 3/23/44

G 15451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1192

G 15451

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Balt.
(c) Hospital or institution: Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Geo
(c) City or town Laurel (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Main Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Meier Turner Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March-9-44

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace West Balt. Gen. Hosp. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward M. Turner Sr.
13. Birthplace Arkansas

MOTHER
14. Maiden Name Agnes Ferguson
15. Birthplace Colorado

16 (a) Informant Edward M. Turner
(b) Address Laurel Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/44 (month) (day) (year)
(c) Cemetery or crematory Ivy Hill
Location Laurel Md

18 (a) Funeral director Lloyd Kaiser
(b) Address Laurel Md.

19 (a) (Signature of registrar) (b) Hunting for Williams, Registrar

MAR 24 1944

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944, at 12 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1944 to March 23 1944 and that I last saw h/m alive on March 23 1944.

Immediate cause of death: Lobar Pneumonia — Duration: 14 days

Due to Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. N. Friedman M. D.
Address West Balt Gen Hosp Date signed 3/23/44

G 15452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15452 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BON SECOUR HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. 1540 - SULPHUR SPRING RD. ARBUTUS-27 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR. HARRY R. JOHNSON
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-09-0245

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife MRS. RONA JOHNSON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5. 1908

8. AGE: Years	Months	Days	If less than one day
35	2	16	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business

FATHER
12. Name Geo. C Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Daisey Kramer
15. Birthplace Md

16 (a) Informant Mrs Rowena Johnson
(b) Address 1540 Sulphur Spring Rd

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 25 44 (month) (day) (year)
(c) Cemetery or crematory Lowden Park
Location Frederick Md

18 (a) Funeral director Harry Wright
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) (Registrar)
MAR 24 1944 Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 21 - 1944 at 12 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 - 8 - 1944 to 3 - 21 - 1944 and that I last saw h.IM alive on 3 - 21 - 1944.

Immediate cause of death	Duration
Menings - Encephalitis	
Due to Menings - Encephalo - Syphilis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Hooton M. D.
Address Baltimore Md. Date signed 3/24/44

VS

G 15453 | BALTIMORE CITY HEALTH DEPARTMENT | G 15453

CERTIFICATE OF DEATH

Registered No. 80a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 Belvedere Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Pinkney Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed~~, or ~~divorced~~
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23-1927

8. AGE: Years	Months	Days	If less than one day
17	1 0	29	hr. min

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Irving C. Hammond
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Hare
15. Birthplace Md.

16 (a) Informant Catherine Hare
(b) Address 3333 Belvedere Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave.

19 (a) MAR 24 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22-44 19 , at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7-44 19 , to 3-22-44 , and that I last saw him alive on 3-22-44

Immediate cause of death

Brain tumor -
Due to pending autopsy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-16-44

Major findings of operation:
Mass in pat fossa

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C Hunter Pearl M. D.
Address Univ. Hosp. Date signed 3-22-44

15454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. G 15454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + John Sts.
(c) Hospital or institution Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/24
(e) Length of stay in Baltimore (yrs., mos., or days) 1/24

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1010 N. Charles St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Warren

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13-1944

8. AGE: Years | Months | Days | If less than one day 1 hr. — min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Charles Marquis Warren
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anne Crawford Postle
15. Birthplace Bethany, West Virginia

16 (a) Informant mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Loch Raven Cemetery, Carnegie

18 (a) Funeral director Frederick Undertaking Co of Washington
(b) Address Wolfe & Madison Sts Balto 5.

19 (a) (Date rec'd by local registrar) Huntington Williams MAR 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1944, at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 19— to — 19—, and that I last saw h— alive on — 19—.

Immediate cause of death Hydrocephalus

Due to Congenital anomaly.

Due to Premature birth & lung complication

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature John G. Murray M.D.
Address 9 E. Chase St. Date March 13-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 15455 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 611 S. Greene Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores Dodson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1941

8. AGE: Years 3 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Samuel Johnson
13. Birthplace S. C.

MOTHER
14. Maiden Name Louise Dodson
15. Birthplace Md

16 (a) Informant Louise Dodson
(b) Address 611 S Greene Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) (day) (year)
(c) Cemetery or crematory Meirkirk Md
Location Prince Georges Co

18 (a) Funeral director Isaiah L Brown Son
(b) Address 108 W Montgomery St

19 (a) MAR 24 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1944, at 3:30 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H J Wollenweber M.D. Medical Examiner
Date signed March 24, 1944.

VS 181

G 15456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 15456 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6206 Pinehurst Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 6206 Pinehurst Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Mary O'Neill Skinner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Wm. Wallace Skinner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1892

8. AGE: Years 51 | Months 9 | Days 24 | If less than one day: hr. min

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Michael J. O'Neill
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Reddington
15. Birthplace Ireland

16 (a) Informant George D. O'Neill
(b) Address 6206 Pinehurst Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) [illegible] (b) [illegible]
(Signature of Registrar) Registrar

MAR 24 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944, to Mch 22 1944, and that I last saw h alive on March 21 1944.

Immediate cause of death: Both cardiac and respiratory collapse — Duration: 12 hrs.
Due to Cerebral hemorrhage (2d hemorrhage)
Due to
Other Conditions Hypertension

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E H Hayward M. D.
Address 115 E Eager St Date signed 3/23/44

C 15457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

C 15457 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Use typewriter if possible. Do not abbreviate. Give full name of deceased. Do not use initials alone. If unknown, say so. Do not leave blanks. If the deceased was married, widowed, or divorced, the name of husband or wife must be given. If child, give name of father and mother. Fill in all items as directly supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Callan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Singe

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 187?

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Peter
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridgit Madden
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 25 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Windfeld
(b) Address 917 Monument Ave

19 (a) [illegible] for Williams H.B. (Registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944, at 2.15 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1 1944, to Mch 23 1944, and that I last saw her alive on Mch 22 1944.

Immediate cause of death	Duration
Acute Dilatation Heart	1 day
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 163 E North Ave Date signed 3/24/44

5458 G 15458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 day
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 8207 Harcourt Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STANLEY SEBASTIAN PIVONSKI

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	215-05-3188	Male	White	Married

6 (b) Name of husband or wife: Mary Elizabeth Pivonski 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1898

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45	10	17		

9. Birthplace Poland. (Town, county, and state)
10. Usual Occupation Tool Engineer
11. Industry or business Anchor Post & Fence Co.

MOTHER / FATHER
12. Name Sebastin Pivonski
13. Birthplace Poland
14. Maiden Name Katherine Gleytek
15. Birthplace Poland

16 (a) Informant Mary Pivonski
(b) Address 4207 Harcourt Rd Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 (a) (Date received by registrar) MAR 24 1944 Huntington Pittman Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1944 to March 28 1944, and that I last saw h alive on March 28 1944.

Immediate cause of death	Duration
Bronchio pneumonia	8 day
Due to Carcinoma of Stomach with metastases	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation March 20 1944
Major findings of operation: Inoperable Carcinoma of Stomach
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Keller M. D.
Address Church Home & Hosp. Date signed 3-27-44

G 15459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106a

G 15459 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 32 E. Fort Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 32 E. Fort Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Kyle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Raymond R. Kyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 5 - 1891

8. AGE: Years 51 | Months 6 | Days 18 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name: George E. Floyd

13. Birthplace: Baltimore Md

MOTHER — 14. Maiden Name: Mary E. Mc Cambridge

15. Birthplace: Baltimore Md

16 (a) Informant: John D. Floyd

(b) Address: 32 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-1944 (month) (day) (year)

(c) Cemetery or crematory: Cedar Hill

Location: A. A. Co. Md.

18 (a) Funeral director: Flynn & Fleming

(b) Address: 1426 Light St.

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 24 1944 Registrar for Williams, M.D.

FS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH - 3/23 1944 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19/44 19... to 3/23 1944. and that I last saw h[illegible] alive on 3/23 1944.

Immediate cause of death

Acute Dilatation Heart. — Duration: 1 day.

Due to: Acute Bronchitis — Duration: 4 days

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. Mbella M. D.

Address 1279 Mulberry St Date signed 3/24/44

G 15460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 15460 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 Cold Spring Lane

(c) Hospital or institution:

Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Mo

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 323 E. 28th St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henrietta Theodora Unkel

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Lewis E. Unkel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1863

8. AGE: Years	Months	Days	If less than one day
80 years	4s	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jacob P. Amendt

13. Birthplace Frankfort Germany

MOTHER 14. Maiden Name Henrietta A. Ritter

15. Birthplace Hanover Germany

16 (a) Informant Mr. Geo. Cook

(b) Address 801 Queen St. Cape, May, N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location East End of North Ave. Baltimore

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.

(b) Address North & Pennsylvania Aves.

19 (a) 3-24-1944 Huntington Williams M.D. (Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1944 at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1943 to March 23 1944, and that I last saw her alive on March 22 1944.

Immediate cause of death Coronary heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. H. Patterman M. D.

Address 2324 Reisterstown Rd Date signed 3/24/44

G 15461

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 15461
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 247 S. Washington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 247 S. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph L. Kutcha (KUCHTA)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 30, 1941

8. AGE: Years	Months	Days	If less than one day
2	273	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Adam Kuchta
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rose Ekstawicz
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Rose Kuchta
(b) Address 243 S. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus (Cem.
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 404 S. Chester Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1944, at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an Enquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions Chronic Otitis Media

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Chester L. Jakubik M.D.
Medical Examiner.
Date signed 3/27/44

15462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57c

Registered No. 6 15462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 Garrett ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA C. WHITEFORD

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
fem	W.	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17 - 1876

8. AGE: Years	Months	Days	If less than one day
67	5	7	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles D Berry
13. Birthplace Md

MOTHER
14. Maiden Name Hanna A. (Atkinson)
15. Birthplace Md

16 (a) Informant Hubert Leatch
(b) Address 2621 Garrett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1219 E Fayette St

19 (a) MAR 24 1944 (Date rec'd by district) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944 at 4 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8 1944 to 3-24 1944 and that I last saw h[illegible] alive on 3-23 1944.

Immediate cause of death	Duration
Cardiac thrombosis	
Due to Hyperpensive cardio vascular disease	
Due to	
Other Conditions Pelvic Tumor	over

(Include pregnancy within 3 months of death)
Date of operation 3-14-44 Colostomy
Major findings of operation: Pelvic Tumor - Intestinal obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. N. Friedman M. D.
Address West Balt. Gen. Hosp. Date signed 3/25/44

15463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G. 15463
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2635 Chesterfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2635 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marguerite E. Davison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Clinton C. Davison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1900

8. AGE: Years	Months	Days	If less than one day
44	2	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Geo. Thuer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Pitts
15. Birthplace Balto. Md.

16 (a) Informant Clinton C. Davison
(b) Address 2635 Chesterfield Ave.

17 (a) Burial (b) Date thereof 3/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1936 E. Lafayette Ave.

19 (a) MAR 24 1944 (b) Huntingtown Williams, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23rd 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1943 to March 22 1944 and that I last saw h alive on March 21 1944

Immediate cause of death	Duration
Coronary Thrombosis	minutes
Due to Hypertension	1 year
Due to Myocarditis	1 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert W. Foster M. D.
Address 2824 St. Paul St. Date signed 3/23/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 15464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58D

G 15464

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MOS. 17 DAS

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 19 N. Ellwood Avenue (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Edgar Muller

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1934

8. AGE: Years	Months	Days	If less than one day: hr.	min.
10	2	6		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER

12. Name Edgar Muller, Sr.

13. Birthplace Balto., Md.

MOTHER

14. Maiden Name Mary Marcantonio

15. Birthplace Balto. Md.

16 (a) Informant Edgar Muller, Sr.

(b) Address 19 N. Ellwood Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-25-44 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler INC.

(b) Address 403 S. WOLFE ST.

19 (a) MAR 24 1944 (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1944 at 8:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1944 to 3-21 1944 and that I last saw him alive on 3-21 1944.

Immediate cause of death Uremia, Cardio-respiratory failure — Duration

Due to Congestive heart failure, renal failure

Due to Rheumatic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John C. Ozazenski M. D.

Address Mercy Hospital Date signed 3-21-44

Huntington Pittsburgh

15465 G 15465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3522 TOONE ST.
(c) Hospital or institution:
.....
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3522 TOONE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH A. GRESS

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APR. 9 1916

8. AGE: Years	Months	Days	If less than one day
27	11	13	..... hr. ..... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business FOR SELF

FATHER
12. Name JOHN H. GRESS
13. Birthplace BALTO.

MOTHER
14. Maiden Name KATIE HOFFMANN
15. Birthplace BALTO.

16 (a) Informant JOHN H. GRESS (FATHER)
(b) Address 3522 TOONE ST.

17 (a) BURIAL (b) Date thereof MAR. 25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeller INC.
(b) Address 403 S WOLFE ST.

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

VS/10 MAR 24 1944

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH MAR. 22 1944 at 9/10 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1944 to March 22 1944, and that I last saw him alive on March 22 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	6 hrs
Due to Arterio-sclerosis	?
Due to Pulmonary Oedema	3 hours
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
.....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. B. Bronushas, M.D.
Address 3037 O'Donnell St Date signed 3-23-44

Attending Phys. Williams, M.D.

G 15466

4b-85298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15466 Registered No. 120

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 E. Bank St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Sinnix (Duckert)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1917

8. AGE: Years	Months	Days	If less than one day
27	-	8	hr min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harvey Sinnix
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Sinnix
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 27-44 (month) (day) (year)
(c) Cemetery or crematory ST STANISLAUS
Location DUNDALK AVE.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) MAR 24 1944 (Date received by registrar) Registrar
(b) Filing [illegible]

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1944, at 10 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28- 1944 to 3-23- 1944 and that I last saw h/m alive on 3-22- 1944.

Immediate cause of death (Pulmonary Tbc.) Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Ehrlich M. D.
Address 4940 Eastern Ave. Date signed 3-23-44

15467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G 15467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 N. KENWOOD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 N. KENWOOD AVE? (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. WHITFIELD

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife PATRICK H. WHITFIELD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 18 1875

8. AGE: Years	Months	Days	If less than one day
68	5	4	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name JOSEPH SMITH
13. Birthplace VA.

MOTHER
14. Maiden Name HELEN WITHY
15. Birthplace VA.

16 (a) Informant PATRICK H. WHITFIELD (HUS)
(b) Address 503 N. KENWOOD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 25/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by local registrar) (b) Registrar

MAR 24 1944

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 22 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1939 to 3/22 1944 and that I last saw her alive on 3/20 1944

Immediate cause of death Coronary Thrombosis — Duration 3 wks.
Due to Hypertension — 4 mo.
Due to Diabetes Mellitus
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis T. Klimes M. D.
Address 2623 E. Monument Date signed 3/23/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

G 15468 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3531 Hough Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3531 Hough Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Scurti

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1892

8. AGE: Years	Months	Days	If less than one day
52	5	23	hr. min.

9. Birthplace Spoltore Italy
(Town, county, and state)

10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Roserio Scurti
13. Birthplace Italy

MOTHER
14. Maiden Name MariaRosa Petrancelo
15. Birthplace Italy

16 (a) Informant Domick Scurti (Nephew)
(b) Address 3812 E. Pratt St.

17 (a) Burial (b) Date thereof March 27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Gorsuch Mill Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 44 at 7:25 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cirrhosis of the liver.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robt L. Feehan M.D.
Medical Examiner.
Date signed March 24, 1944.

G 15469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15469 Registered No. 121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 W. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis B. Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-9318

4. Sex M.

5. Color or race C.

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Willa Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1902

8. AGE: Years 42 | Months - | Days 22 | If less than one day hr. min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lewis Harrison
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Carmack
15. Birthplace Md

16 (a) Informant Ella Harrison
(b) Address 3111 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph G. Locke
(b) Address 1304 N. Central Ave

19 (a) MAR 24 1944 (b) [illegible] Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1944 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1944 to 3/21 1944 and that I last saw him alive on 3/21 1944.

Immediate cause of death Chr Interstitial Nephritis — Duration unknown
Due to Cardio-Vascular Disease — "
Hypertension. — "
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 711 N. Pechiston St Date signed 3/22/44

VS 8

G 15470

AB-78190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15470 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr- 3mos-27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1646 Abbott st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Green
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced Separated
6 (b) Name of husband or wife George
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 23-1887 -?
8. AGE: Years 56 ? Months 10 ? Days 28? 24 If less than one day hr min
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Bush
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Butler
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cemetery
Location St. Mary's County
18 (a) Funeral director Joseph B. Funk, Jr.
(b) Address 1304 N. Central Ave
19 (a) (Date rec'd by registrar) (b) Registrar

VS 750

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1944 at 12 00

21. I certify that death occurred on the date above stated, that I attended deceased from 11/24 1943 to 1/22 1944, and that I last saw h[er] alive on 1-22 1944

Immediate cause of death
Pneumonia
Duration 12 days

Due to Hypertensive cardio vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address B. C. H. Date signed 3/24/44 M. D.

Every item of information should be carefully supplied correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 15471

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15471 Registered No.

12/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3906 Forrester Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State Md b County
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 3906 Forrester Ave (If rural give location)
e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. Kesterveld - Ohlendorf
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife Joseph B. Kesterveld 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 78 Months Days If less than one day hr min.
9. Birthplace Baltimore - Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

MOTHER / FATHER
12. Name Charles J. Ohlendorf
13. Birthplace Germany
14. Maiden Name Mary T. Kashbaugh
15. Birthplace Germany

16 (a) Informant Mrs. M. B Johnson
(b) Address 3906 Forrester Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.
19 (a) (b) (Registrar's signature) (Registrar)

MAR 24 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944, at 2 30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-14-1944, to 3-22-1944, and that I last saw her alive on 3-21-1944.

Immediate cause of death	Duration
Cardio-renal disease	unknown
Due to arteriosclerosis	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Geo B. Sylvest M. D.
Address 2802 Harford Rd Date signed 3-24-44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 15672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15672 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 White Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore
(If outside city or town limits, write RURAL and give town)
d Street No. 3009 White ave
(If rural give location)
e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Gray

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Mary E. Barker
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug 3 - 1873

8. AGE: Years	Months	Days	If less than one day
70	7	20	hr min.

9. Birthplace Baltimore Co. - Md
(Town, county, and state)
10. Usual Occupation Retired - C & P
11. Industry or business Telephone Co.

FATHER
12. Name William Gray
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Annie Stebt
15. Birthplace U. S. A.

16 (a) Informant Mrs Mary E. Gray
(b) Address 3009 White ave.

17 (a) Burial (Burial, cremation, or removal) b Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Kurtz
(b) Address 3305 Harford Rd

19 (a) (Date rec'd by registrar) b Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23 19 44 at 8 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Mar. 23 - 1944.
and that I last saw h im alive on 3/23/ 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage.	
Due to Arteriosclerosis.	
Due to Debility.	
Due to Hypertension.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. B. Boyle. M. D.
Address 5217 Harford Rd Date signed

VS 150

B 15473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

B 15473 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4309 Arabia Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 4309 Arabia Av (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Margaret Casey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29-1865

8. AGE: Years 79 | Months 1 | Days — | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation housework

11. Industry or business Home

FATHER
12. Name Patk. J. Casey
13. Birthplace Ireland.

MOTHER
14. Maiden Name Ellen Curley
15. Birthplace Ireland

16 (a) Informant Ella Casey
(b) Address 4309 Arabia Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May [illegible] 44

(c) Cemetery or crematory Mass. Cath.
Location Old Frederick Rd.

18 (a) Funeral director John. J. Hogan
(b) Address 3000 E. Balto.

19 (a) 3/26/44 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944, at 6:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1943, to Mar. 24 1944, and that I last saw h[illegible] alive on Mar. 23 1944

Immediate cause of death: Myocarditis — Duration: 4 days

Due to —

Due to —

Other Conditions Chronic Bronchitis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Benj. D. Hayden, M. D.
Address 3114 Hartford Rd Date signed 3/24/44

G 15474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927

G 15474
Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6209 44th Ave - Riverdale Md.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Etowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Annie Etowski | 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 7, 1875

8. AGE: Years 68 | Months 10 | Days 16 | If less than one day: hr. | min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name John Etowski
13. Birthplace Germany

MOTHER
14. Maiden Name Frances ?
15. Birthplace Germany

16 (a) Informant Bernard S. Etowski (son)
(b) Address 6209 - 44th Ave, Riverdale, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1927 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location G.G. Co., Md.

18 (a) Funeral director A. J. Bernard Evans
(b) Address 1400 St. Charles St (30)

19 MAR 24 1927 (Date received by registrar) (b) [illegible] (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1927 at 5:A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3, 21 1944 to 3/23 1927, and that I last saw h (M) alive on 3/23 1927

Immediate cause of death Cardiac Degeneration - Coronary Failure

Due to Cerebral Hemorrhage Accident

Due to Hypertrophic Cardio-vascular Disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Goodden

Address City Hospital Date signed 3/25/27 M. D.

G 15875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

G 15875
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1144 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 y
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 Hanover
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Fella

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Wht	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1856

8. AGE: Years	Months	Days	If less than one day
88	1	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired schoolteacher
11. Industry or business Public Schools

FATHER
12. Name Geo. W. Fella
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Elizabeth A. Mills
15. Birthplace Balto., Md.

16 (a) Informant Howard P. Fella (Brother)
(b) Address 1144 Hanover St. (30)

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location G. A. Co., Md

18 (a) Funeral director G. Howard Evans
(b) Address 1400 S. Charles St (30)

19 (a) (b)
(Signature of registrar) (Registrar)

MAR 24 1944

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1944 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1943, to 2-23 1944, and that I last saw h[illegible] alive on 3-22 1944.

Immediate cause of death
Chronic Myocardial Degeneration
Due to Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 yr.
2 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Fallood
Address 707 E. Fortieth Date signed 3-24-44 M D

Please write plainly, with ink. Spelling of names and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15476 1429 E Chase

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22a

G 15476 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1257 Orleans st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1251 Orleans (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George a Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-7-1908.

8. AGE: Years	Months	Days	If less than one day
35	4	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Geo Young
13. Birthplace Va

MOTHER
14. Maiden Name Fannie Claybourne
15. Birthplace Va

16 (a) Informant Fannie Lewis
(b) Address 1251 Orleans st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. G. Co Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

MAR 24 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 1944 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25, 1944 to Mar 22 1944 and that I last saw h alive on Mar 22 1944.

Immediate cause of death	Duration
Tuberculous endocarditis	1 day
Due to Acute Miliary Tuberculosis	1 day
Due to La Grippe	1 month

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Jackson M. D.
Address 1401 Chase Date signed 3-24-44

Huntington Williams, M.D

Please write clearly, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. 15477

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 540 N. Calvert Street

(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 540 N. Calvert Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELSIE BRADY

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Roy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2 [illegible]

8. AGE: Years	Months	Days	If less than one day
66		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Jacob Anderson

13. Birthplace Baltimore, Maryland

MOTHER

14. Maiden Name Clara Ruark

15. Birthplace Salisbury, Maryland

16 (a) Informant Mr. Robert Penland

(b) Address 640 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 25 44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location [illegible]

18 (a) Funeral director William Cook, Inc.

(b) Address 1217 St. Paul Street

19 (a) [illegible] (Date rec'd by registrar) (b) Huntington Pennsylvania Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23 1944, at about 4 21. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1943 to Mar 1944, and that I last saw h[illegible] alive on Mar 19 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension Cardio-Vascular Renal	
Due to	
Other Conditions Chronic Cholistatis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address 3402 Eutaw Ave Date signed 3/28/44

G 15478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15478 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 539 Richmond Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 539 Richmond Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Elizabeth Cutajar

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 1876

8. AGE: Years 68 | Months 1 | Days 13 | If less than one day hr min

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Wilson Patterson

13. Birthplace Baltimore Md

14. Maiden Name Elizabeth Unknown

15. Birthplace Germany

16 (a) Informant Joseph Cutajar

(b) Address 539 Richmond Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month, day, year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Conroe

(b) Address 1217 E Lanvale St

19 MAR 25 1944 (Date received by registrar) MAR 27 1944 Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944, at 1 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1944, to 3-24 1944, and that I last saw her alive on 3-24 1944

Immediate cause of death

[redacted] Paget's Disease

Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M McGoldrick M. D.

Address 6014 York Road Date signed 3-24-44

PHYSICIAN

Underline the cause to which death should be charged statistically

VS 150

PLEASE WRITE PLAINLY, with ink. Fill in all blanks. Be sure and give cause of death clearly and legibly. Physicians: please write the cause of death in such terms and such only as will correctly represent the disease or condition which caused death, or in the absence of any disease or condition directly causing death, the circumstances of the accident or violence which produced death. Do not use abbreviations or symbols. Do not state the mode of dying, such as heart failure, asphyxia, anemia, or uremia. Do not record occupations that are indefinite, such as laborer, clerk, etc. Indicate the kind of work done during most of working life, even if retired before death. Be sure to answer every question. Where there is no person in charge of the body, the coroner should fill out and sign the certificate. Please write plainly with pen and ink. Use figures for dates. Be particularly careful to write correct age in every case.

15479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 15479

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1202 Valley Street

(c) Hospital or institution: Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a State Md. b County

c City or town Baltimore

(If outside city or town limits, write RURAL and give town)

d Street No. 1202 Valley St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charles MacLean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of ~~husband or~~ wife Annie C. MacLean

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7th 61

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	6	17		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Roger Mac Lean

13. Birthplace Md.

MOTHER

14. Maiden Name Annie (Unknown)

15. Birthplace

16 (a) Informant Little Sisters of the Poor

(b) Address 201 Valley Street

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/25/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Loudon Park

Location Balto. Md.

18 (a) Funeral director William Cook Co.

(b) Address 1 E. Preston St.

19 (a) MAR 25 1944 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to March 24 1944, and that I last saw him alive on March 24 1944.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Interstitial Nephritis	4 yr.
Due to Chronic Myocarditis	3 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. Gill Hall M. D.

Address 163 E Madison Date signed 3/24/44

VS 150

G 15480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15480 Registered No.

1-17a

PLEASE WRITE PLAINLY, with unfading ink. Use typewriter if possible. Do not abbreviate. Give full name of deceased. If not in hospital or institution, give residence instead of institution. If residence unknown, give length of residence in place where death occurred. If deceased was a child, fill in items 12 to 15. If deceased was married, widowed, or divorced, give name of husband or wife. If deceased was a married woman, give her maiden name. Please answer all questions. If none, write NONE. If unknown or if the question does not apply, write UNKNOWN. Physicians: please write the causes of death clearly and legibly. Please state duration correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Gene
(c) Hospital or institution: University Hosp 4th
(d) Length of stay in hospital or inst. yrs., mos., or days 3 days
(e) Length of stay in Baltimore yrs., mos., or days 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Barton (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Darlene Broadwater.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 1 Months 3 Days If less than one day hr min

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER 12. Name Wheeler Broadwater

13. Birthplace Md

MOTHER 14. Maiden Name Edna Warnick

15. Birthplace Md.

16 (a) Informant Wheeler Broadwater

(b) Address Barton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)

(c) Cemetery or crematory Family Cemetery

Location Barton Md

18 (a) Funeral director Wm. J. Kemp

(b) Address Wolfe & Gelmo Huntington Williamsport Md

19 MAR 25 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-44 19 at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21-44 19 to 3-24-44 19, and that I last saw her alive on 3-24-44

Immediate cause of death Shock. — Duration

Due to Cerebellar exploration

Due to Hydrocephalus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-24-44

Major findings of operation: Basilar arachnoid adhesions

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify home, farm, industrial place, etc.)

(e) Means of injury

23. Signature E. Lantz Gail M.D.

Address Clinic. Hosp Date signed 3-24-44

G 15481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 15481 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Mary E. Nitchman,

3 (b) If veteran, name war: --

3 (c) Social Security Account No. ---

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John H. Nitchman,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1867

8. AGE: Years 76 Months 10 Days 13 If less than one day hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: Conrad Birx,
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Miller,
15. Birthplace: Germany

16 (a) Informant: Mrs Charlotte D. Swartzman
(b) Address: 1004 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 27, 1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore

18 (a) Funeral director: Robert S. Little,
(b) Address: 2700 Edmondson Ave.

19 (a) (b) Thurlington Williams, M.D. Registrar

Filed by Registrar MAR 28 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 23 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9-44 19 . to 3-23-44 19 . and that I last saw h e alive on 3-23 44 19 .

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 wks

Due to: Arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Harry S. Gimbel M. D.

Address 2763 Edmondson Date signed 3-24-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15482 — BALTIMORE CITY HEALTH DEPARTMENT — G 15482 Registered No.

CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 N Fayette
(c) Hospital or institution: Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby Geraldine Louise Kasper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-44. 7 A.M.

8. AGE: Years	Months	Days	If less than one day
—	—	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alfred Antony Kasper
13. Birthplace Baltimore / Maryland

MOTHER
14. Maiden Name Marta louise Smith
15. Birthplace Dorsey, Maryland

16 (a) Informant Alfred A. Kasper
(b) Address 1123 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 25-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director George L. Schnorr
(b) Address 2101 Eutaw Pl.

19 (a) MAR 25 [illegible] Washington Village, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1944 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1944 to 3/23 1944 and that I last saw he alive on 3/23 1944.

Immediate cause of death	Duration
Congenital Atelectasis	7 Days
Due to	
Due to	
Other Conditions Malformation of Rectum	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raymond Rogers, M.D.
Address 1123 N. Pulaski St Date signed 3/25/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

G 15483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310 G 15483

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 554 Orchard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 554 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Newman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, [illegible]97

8. AGE: Years	Months	Days	If less than one day
47	5	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Phillip Newman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ceasar
15. Birthplace Md.

16 (a) Informant Mrs. Bessie Curtis
(b) Address 554 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem;
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) MAR 25 1944 (b) Huntingtown Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March, 22, 1944, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to 3/22 1944, and that I last saw h[illegible] alive on 3/22 1944.

Immediate cause of death: Uremia - Renal

Duration: 2 hrs 2 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Huntington Williams M. D.
Address 1 W Saratoga Date signed 3/25/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G 15484 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 569 Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 569 Monroe St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George P. Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Aug 20, 1877

8. AGE: Years	Months	Days	If less than one day
68	7	7	hr. min.

9. Birthplace Richmond Co - Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Laura Thompson
(b) Address 569 Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto Co, Md.

18 (a) Funeral director Mgr Frances A Hemsley
(b) Address 578 W. Biddle St.

19 (a) 3-25-1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 mo/44 19 Died M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8-44 to 3-22-44 and that I last saw h alive on 3-22-44

Immediate cause of death Pneumonia
Resulting from Myocarditis

Due Contributory

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Cn Taylor M. D.
Address 924 Park Ave Date 3 mo 24 44

G 15485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15485 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3821 Hickory Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3821 Hickory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara B. Wilhelm.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married.

6 (b) Name of husband or wife Clarence M. Wilhelm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1865

8. AGE: Years	Months	Days	If less than one day
79	2	—	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Daniel Kyte
13. Birthplace Maryland

MOTHER 14. Maiden Name Catherine Zimmerman
15. Birthplace Maryland.

16 (a) Informant Clarence M. Wilhelm
(b) Address 3821 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 25/44 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Balto Co, Md.

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Chestnut Ave.

19 MAR 25 1944 (Date received by registrar) Huntington Williams (Signature) M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1944, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944 to March 22 1944; that I last saw her alive on 3-22 1944.

Immediate cause of death: Cerebral Thrombosis — Duration: 1 wks
Due to arteriosclerotic CVD
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lawrence Hamank M. D.
Address 3711 Falls Rd Date signed 3-27-44

G 15486

G 15486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4011 Kathland Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4011 Kathland Ave.
(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME JANIE CHANDLER BANKS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Andrew Lee Banks

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12/12/1867

8. AGE: Years	Months	Days	If less than one day
76	3	11	hr. ..... min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Fielder Bowie Boswell

13. Birthplace Calvert Co., Md.

MOTHER

14. Maiden Name Lucy Gantt

15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs Clinton L. Banks

(b) Address 1213 W. Belvedere Ave.

17 (a) Burial (b) Date thereof 3/27/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address ..... Balto., Md.

19 MAR 25 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/ 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1939 to March 23 1944, and that I last saw h alive on March 23 1944.

Immediate cause of death

Cardiac insufficiency

Due to Arteriosclerosis

Due to .....

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration
7
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury .....

23. Signature Samuel Gann M. D.

Address 1261 E. Mt. St. Date signed 3/25/44

G 15487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20 E

G 15487 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Frambard & Green
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto,
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Hilton Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY KRIEGER HILBERT

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Minna D. Hilbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1890

8. AGE: Years 53 | Months 4 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Wholesale Mnfct. Optician
11. Industry or business Self

FATHER
12. Name George Hilbert
13. Birthplace Charlestown, W. Va.

MOTHER
14. Maiden Name
15. Birthplace unknown

16 (a) Informant Mrs. Minna Hilbert
(b) Address 3503 Hilton Rd. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 25 1944 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/ 1944, at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1944 to 3-23 1944, and that I last saw h alive on 3-23 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Senile C.V.D.

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M E. Robertson M. D.
Address Univ. Hospital Date signed 3-24-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 15488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G [illegible]

Registered No. [illegible]

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2117 Denison St.

(c) Hospital or institution:

Crawford Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 641 W. Lafayette Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR JOHN APPLEGARTH

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1859

8. AGE: Years	Months	Days	If less than one day
84	9		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Bookkeeper

11. Industry or business

FATHER 12. Name John A. Applegarth

13. Birthplace unknown

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs. Frances E. Pritchard

(b) Address 3604 Plateau Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) MAR 25 1944 Huntington Williams (Registrar)

(b) Registered by (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1944, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to March 24 1944, and that I last saw h[illegible] alive on 3-23 1944.

Immediate cause of death: Myocardial failure - arteriosclerosis
Myocarditis — Duration: ?

Due to Generalized arteriosclerosis — Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thomas Bochreiber M. D.

Address 545 S. Bolton Ave Date signed 3-25-44

Please answer questions in ink, with CAPADINO INK. Every item of information should be answered. If any question does not apply, write "none." Be sure to give full name of deceased, and correct age in every case. Underline the cause to which death should be charged statistically. Physicians: please write the causes of death clearly and legibly.

G 15489

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15489 Registered No. 91a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp.
(c) Hospital or institution:
University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Jane Cutsail
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife George Cutsail
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1927

8. AGE: Years	Months	Days	If less than one day
17	1	1	hr. min

9. Birthplace Sykesville, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Nathan C. Hobbs
13. Birthplace Md

MOTHER
14. Maiden Name Gertrude S. Hood
15. Birthplace Md.

16 (a) Informant Nathan C. Hobbs
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Springfield Cemetery
Location Sykesville, Md.

18 (a) Funeral director C. Harry Kiser
(b) Address MAR 25 1944 ville, Md.

19 (a) (Date rec'd by registrar) Hattie Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1944, at 5.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1944, to 3-24 1944 and that I last saw HER alive on 3-24 1944.

Immediate cause of death
Cardiac insufficiency
Due to Subacute Bacterial Endocarditis
Due to Strept Viridans

Other Conditions hemiplegia
Gave birth to infant 3-9-44
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm N. Copeman M. D.
Address University Hosp. Date signed 3/24/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15490 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 W Lanvale St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 W Lanvale St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Rebecca Shreve

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Arthur L. Shreve

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 18 1867

8. AGE: Years 76 | Months 4 | Days 6 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Levin Gale
13. Birthplace Maryland

MOTHER
14. Maiden Name Sallie A. Dorsey
15. Birthplace Maryland

16 (a) Informant Mrs Dorsey W. Waples (daughter)
(b) Address 127 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart Memorial Co.
(b) Address 1818 W North Ave

19 (a) MAR 25 1944 (Date rec'd by registrar) Waiting for Physician's Cert. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 1944 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1936 to 3/24 1944, and that I last saw h-r alive on 3/24 1944.

Immediate cause of death: Coronary Thrombosis — Duration 30 min.
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions: Myocarditis — Gradual

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M A Shively M.D.
Address 140 S Paca Date signed 3/24/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15491

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

121B

G 15491 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3303 Glenn Ave
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 07
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Glen Ave (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Grace Estelle Pullen

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chas. H. Pullen

(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug-25-1884

8. AGE: Years 59 | Months 6 | Days 26 | If less than one day: hr. min. 7

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name John Boone
13. Birthplace England

MOTHER
14. Maiden Name Eliza Bailey
15. Birthplace England

16 (a) Informant Mr. John C. Pullen (son)
(b) Address 3303 Glen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-44 (month) (day) (year)
(c) Cemetery or crematory Mendal Brunch
Location Carroll Co. Md

18 (a) Funeral director Stewart Mort Co.
(b) Address 1618 W Mosher Ave

19 MAR 25 1944 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 22 1944 at 6.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 14 1944 to MAR 22 1944 and that I last saw h[illegible] alive on MAR 22 1944

Immediate cause of death: Chronic Nephritis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos D. Bubert M. D.

Address 1603 Eutaw Heights Ave Date signed 3/23/44

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G 15492 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 N. Greene St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country America

3 (a) FULL NAME Mr. Joseph Carnaggio

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1868

8. AGE: Years	Months	Days	If less than one day
75	6	7627	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Produce Dealer.
11. Industry or business Self

FATHER
12. Name Vincent Carnaggio
13. Birthplace Italy

MOTHER
14. Maiden Name Rosina Carrera
15. Birthplace Italy

16 (a) Informant MR. Frank Leroy.
(b) Address 303 N. Greene St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director John F. Gowan & Son
(b) Address 901-03 Baltimore St.

19 MAR 23 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 19 44 at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 19 44 to 3/24 19 44
and that I last saw h alive on 3/23 19 44.

Immediate cause of death: Bronchogenic Carcinoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Arthur Rosberg

Address St. Agnes Hosp. Date signed 3/27/44

G 15493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15493 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3808 Fear Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 6years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Fear Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Washington Bell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Samuel J. Bell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 17, 1850

8. AGE: Years	Months	Days	If less than one day
93	11	6	— hr. — min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Ezekiel Carter
13. Birthplace Virginia

MOTHER
14. Maiden Name Melinda Redmann
15. Birthplace Virginia

16 (a) Informant Charles H. Bell
(b) Address 548 Allegheny Ave., Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Sater's Baptist Cem.
Location Chestnut Ridge, Balto. Co., Md.

18 (a) Funeral director John Barnes' Sons
(b) Address Towson, Maryland.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1944 at 6:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Mar. 23 1944, and that I last saw ~~him~~ her alive on 22 1944.

Immediate cause of death Chronic myocarditis.

Duration 6 Dys

Due to General debility.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. H. Phillips M. D.
Address 1939 Edmondson Ave. Date signed 3-24-44

VS 150

G 15494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

G 15494 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 N. Eden street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Eden St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Harriet Elizabeth Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem

5. Color or race colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Thos. T. Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 79 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name James H. Cummings
13. Birthplace Maryland

MOTHER
14. Maiden Name Don't Know
15. Birthplace

16 (a) Informant Chas Johnson (son)
(b) Address 815 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 24 (day) 44 (year)

(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 421 Jefferson St

19 (a) MAR 25 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 1944, at 3:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21, 1943 to Mar 22, 1944, and that I last saw her alive on Mar 21 1944.

	Duration
Immediate cause of death Senile Debility and Pneumonia	3 Days
Due to Chron. Nephritis	6 mos.
Due to Neurasthenia	2 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Grant Heath M. D.
Address 324 W. Biddle St Date signed 3-23-44

VS 3

correct age is especially important. Physicians, please write the causes of death clearly and legibly.

G 15495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 15495

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 McElderry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 McElderry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Inggle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	col.	Married

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Sidney Inggle
13. Birthplace Va

MOTHER
14. Maiden Name Percilla Rawley
15. Birthplace Va

16 (a) Informant Josephine Inggle
(b) Address 1521 McElderry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A Ave & Hoffman

18 (a) Funeral director Robert E Gilligan
(b) Address 1515 McElderry St

19 (a) MAR 26 1944 (Date received by Registrar) Hunter for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1944 at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1944 to 3-22 1944 and that I last saw h~~e~~ alive on 3-22 1944.

Immediate cause of death
Cerebral Hemorrhage — Due to Hypertension — Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration
1 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Fisher M. D.
Address 1542 E Monument Date signed 3/24/44

Please write plainly, with pen and ink. Physicians: please write the causes of death clearly and legibly. Statements of date, place and cause of death are required by law. Accurate and correct age is especially important.

G 15496 ✓ G 15496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 86

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St Marys
(c) City or town Great Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R Adams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-43

8. AGE: Years	Months	Days	If less than one day hr.	min.
	11	14		

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Adams
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Sheyherd
15. Birthplace Wash - D.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-44 (month) (day) (year)
(c) Cemetery or crematory Holy Face
Location Great Mills, Md

18 (a) Funeral director H.C. Mattingley Sons
(b) Address Leonardtown, Md

19 MAR 26 1944 (Date rec'd by registrar) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 25 1944, at 2.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 16 1944, to MAR 25 1944, and that I last saw him alive on MAR 25 1944.

Immediate cause of death Respiratory failure.
Due to Convulsions.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
10 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp Date signed 3-25-44

VS 150

G 15497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

64

G 15497
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 670 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 670 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Finch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced?
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1943

8. AGE: Years	Months	Days	If less than one day
	7	20	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wiley Finch
13. Birthplace N. C.

MOTHER
14. Maiden Name Edith Randolph
15. Birthplace Balto. Md.

16 (a) Informant Edith Finch
(b) Address 670 W. Mulberry Street

17 (a) Removal (b) Date thereof March 25, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Burkeville Virginia

18 (a) Funeral director Mrs. R. A. Elliott & Daughter
(b) Address 1129 N. Carolina Street

19 (a) MAR 20 1944 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944, at 10:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Status thymico-lymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 3-24-44

correct age is especially important

G 15498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114E

G 15498 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Jan. 18, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1925

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Presstman Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES WATKINS

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Rebecca Harris
6 (c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): Apr. 18, 1896

8. AGE: Years: 47 | Months: 11 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Lynchburg, Va.
(Town, county, and state)

10. Usual Occupation: Laborer 1942

11. Industry or business:

FATHER
12. Name: Rubin Watkins
13. Birthplace: ?

MOTHER
14. Maiden Name: Angeline Landon
15. Birthplace: Lynchburg, Va.

16 (a) Informant: Records, U.S.Marine Hospital
(b) Address: Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/25/44 (month) (day) (year)
(c) Cemetery or crematory
Location Lynchburg Va

18 (a) Funeral director Isaiah R Brown Son
(b) Address 1818 Montgomery Street

19 (a) (Undertaker or funeral director) (b) Huntington Hilliard M.D.

MAR 26 1944

VS 186

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH March 21, 1944, at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18, 1944, to Mar. 21, 1944, and that I last saw him alive on Mar. 21, 1944.

Immediate cause of death: Pulmonary fibrosis — Duration: Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Place)
(e) Means of injury

23. Signature J. C. Archer M.D.
Address Baltimore, Md. Date signed 3/21/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Va-14246

G 15499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 15499 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any error or omission in name, date or age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: Sinai Hosp 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2528 Loyola Northway (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Fannie Rocklin ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	Wd.

6 (b) Name of husband or wife Meyer D.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name –

13. Birthplace Russia

MOTHER

14. Maiden Name –

15. Birthplace Russia

16 (a) Informant Paul Rocklin

(b) Address 3525 Forest Pk. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rogedale

Location Jack Levin Inc 1439 E. Balto. St

18 (a) Funeral director .....

(b) Address .....

19 (a) MAR 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1944 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1944 to 3/26 1944 and that I last saw her alive on 3/26 1944

Immediate cause of death Pulmonary edema

Due to Hypertensive C.V. Disease

Due to .....

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury .....

23. Signature Murray Lerner M. D.

Address Sinai Hosp Date signed 3/26/44

VS 150

G 15500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 15500 Registered No. 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital, Balto.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Pasadena Md (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ida Hillman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widow

6 (b) Name of husband or wife Dam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Moses

13. Birthplace Russia

MOTHER 14. Maiden Name Anna Enton Herring

15. Birthplace Russia

16 (a) Informant Isadore Hillman

(b) Address Pasadena Md

17 (a) Baltimore (b) Date thereof 3-26-44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem.

Location Wash. Blvd.

18 (a) Funeral director Joseph Levin Inc

(b) Address 1439 E. Balto St

19 (a) MAR 26 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944, at 12.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1944, to March 25 1944, and that I last saw her alive on March 25 1944

Immediate cause of death Cardio-respiratory failure

Due to Metastatic carcinoma of thoracic cage, shoulder girdle, & pleura.

Due to Carcinoma of breast

Other Conditions Rheumatic Ht. Dis. Pleural Effusion, rt. Fracture of shaft (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
ca 2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Alfred H. Dam M. D.

Address Sinai Hosp., Balto. Date signed 3/25/44

G 15501 7 1944

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G 15501

CERTIFICATE OF DEATH 462

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore City
City or town: 216 Longwood Rd Roland Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
216 Longwood Rd.
How long in hospital or institution? 7

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: B C
City or town: McHendree
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Richard Boyle Sellman Duckett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Margaret Duckett

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age: years

8. AGE: Years: 70 | Months | Days | If less than one day: hrs. min.

9. Birthplace: McHendree B C Co Md
(Town, county, and state)

10. Usual occupation: Ret. Farmer

11. Industry or business

FATHER 12. Name: Rusty Duckett
13. Birthplace: Md.

MOTHER 14. Maiden name: Mary Duckett
15. Birthplace: Md.

16. Informant: Mrs T Ring
Address: 216 Longwood Rd. Balt Md

17. Burial (Burial, cremation, or removal, which?) Date thereof: 3/27/44 (month) (day) (year)
Cemetery or crematory: Mt Jarus
Location: Trudys Md.

18. Funeral director: T A Hardesty & Son
Address: Glenville Md

MAR 26 1944

19. Filed ..... 19..... Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 March 1944, at 1:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 1943 to 23 March 1944 and that I last saw h[illegible] alive on 23 Mar. 1944

Immediate cause of death: Cerebral hemorrhage:
[illegible] a carcinoma of [illegible] months.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Emily H. Linton, M.D.
M. D. or other

Address: Linton Md. Date signed: 3/25/44

Is especially important. Physicians: please write the cause of death clearly and legibly.

G 15502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 15502 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1626 N. SHALLWOOD ST
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1626 N. SHALLWOOD ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNY LAHN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife WILLIAM H. LAHN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
72			hr min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant MATTHEW LAHN - SON
(b) Address 1626 N. SHALLWOOD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-26-44 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila. RD. & HAMILTON AVE

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St
(c) Huntington Williams Mgr

MAR 26 1944 (Date received by registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23-44 19 , at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 44 to March 23 19 44, and that I last saw h[illegible] alive on March 23 19 44

Immediate cause of death Coronary Thrombosis — Duration acute

Due to Coronary Arteriosclerosis — Duration ?

Due to Chr. Endocarditis — Duration ?

Other Conditions Chr. Emphysema — Duration ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marcel Levington M. D.
Address 4002 E. Balto St Date signed 3/27/44

G 15503

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

944[redacted] Registered No. 15503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correctness is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2654 Oswego Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2654 Oswego Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Sherman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Kate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day: hr.	min.
55				

9. Birthplace Leith (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Leith

MOTHER
14. Maiden Name Jennie
15. Birthplace Leith

16 (a) Informant Kate Sherman
(b) Address 2654 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Phila. Pa.

18 (a) Funeral director Jack Reiss Inc
MAR 28 1944 1739 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

VS 180 For W. R. L. Graham, by Howard J. Sheldon, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1944, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1944, to 3-24 1944, and that I last saw him alive on Dead on arrival

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Blum, M.D.
Address 3431 Park Heights Ave Date signed 3/24/44 M. D.

G 15504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G 15504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 N. Pulaski St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 N. Pulaski
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD BLAKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Warsaw Poland
(Town, county, and state)

10. Usual Occupation Musician

11. Industry or business

FATHER
12. Name X
13. Birthplace X

MOTHER
14. Maiden Name X
15. Birthplace X

16 (a) Informant Robert Blake
(b) Address 1515 N. Pulaski St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1432 E. Baltimore St

19 (a) MAR 29 1944 (Date received by Registrar) (b) Burial Permit No.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25 1944, at 12 30 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. L. Wallenmeyer M.D.
for Medical Examiner.
Date signed 3-25-44

G 15506 ✓

BALTIMORE CITY HEALTH DEPARTMENT XV G 15505

CERTIFICATE OF DEATH 183

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given (if unknown, so state). The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Bronx N Y (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Loring Place (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** EPHRAIM SCHAPIRO

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	School Boy

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19 1928

8. AGE: Years	Months	Days	If less than one day
15	7	5	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Austria

MOTHER
14. Maiden Name Rose
15. Birthplace Austria

16 (a) Informant Hospital records
(b) Address

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 3-26-44 (month) (day) (year)
(c) Cemetery or crematory N.Y. City
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Baltimore St

MAR 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 44 at 4 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-24-44 at 11/3 M.
(b) Where did injury occur? Madison & Eutaw Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 3-25-44

G 15506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G 15506 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital, Baltimore 8 E

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1529 N. Broadway (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Katherine Dorsey

3 (b) If veteran, name war: —

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1872

8. AGE: Years 71 | Months 6 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace —

MOTHER 14. Maiden Name —

15. Birthplace —

16 (a) Informant Mrs Louis Weller

(b) Address 3407 Parkside Drive

17 (a) burial (Burial, cremation, or removal) (b) Date thereof March 28, 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director Wm. Cook, Jr.

(b) Address 127 S. Howard St.

(Accepted by registrar) (b) Washington Williams, M.D. Registrar

MAR 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944, at 1605 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 20 1944, to Mar. 24 1944, and that I last saw her alive on Mar. 24 1944.

Immediate cause of death: Cardio-respiratory failure

Due to Uremia

Due to Cerebral Embolism

Other Conditions Rheumatic Ht. Dis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 5 days

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Alfred H. Dann M. D.

Address Sinai Hosp., Balto. Date signed 3/24/44

VS 150

15507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15507 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1811 W. Lafayette Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1811 W. Lafayette Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Maurice B. Ritter

3 (b) If veteran, name war W

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Jennie Virginia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1885

8. AGE: Years	Months	Days	If less than one day
58	8	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Baltimore Transit Co.

FATHER

12. Name Lum Ritter

13. Birthplace Baltimore, Maryland

MOTHER

14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant Jennie Ritter

(b) Address 1811 W. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29, '44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.

(b) Address 1217 St. Paul Street

MAR 26 1944 (b) Huntington Williams, M.D.

(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 23 1944, to Mar 25 1944, and that I last saw h alive on Mar 23 1944.

Immediate cause of death

(a) Chronic valvular heart disease ?

(b) M. S. Syphilis ?

Due to

Due to

Other Conditions Cardiac decompensation Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature I. U. Krenzer M. D.

Address 402 E. Lanvale St. Date signed 3-25-44

G 15508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15508
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 E 21st St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FREDERICK W. HELLER

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed or divorced~~
M	W	Sing e

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 86

8. AGE: Years	Months	Days	If less than one day hr.	min.
57	8			

9. Birthplace Balto. Md. (Town, county and state)
10. Usual Occupation Painter
11. Industry or business Journeyman

FATHER
12. Name Robert Heller
13. Birthplace Germany

MOTHER
14. Maiden Name Julie
15. Birthplace Germany

16 (a) Informant Marie James
(b) Address 204 S. Robinson St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3 28 44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Lawn
Location Edmondson Avenue

18 (a) Funeral director William Cook Inc
(b) Address 1516 E. Fayette St

19 (a) MAR 26 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 1944, at P 400 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. (Medical Examiner.)
Date signed 3-24-44

VS 151

G 15509

450342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Jackson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Beverly Meyers
3 (b) If veteran, name war W
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-1-44

8. AGE: Years	Months	Days	If less than one day
	1	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name George Meyers
13. Birthplace Md.

MOTHER
14. Maiden Name Renee Bonneville
15. Birthplace Fla.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location B. A. Co. Md.

18 (a) Funeral director Williams Bros Inc
(b) Address 227 E. Pleasant St

19 (a) Huntington Williams, M.D.
(Date received by registrar)
MAR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944 at 3 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1944 to Mar 24 1944 and that I last saw h alive on Mar 24 1944

Immediate cause of death Respiratory failure — Duration
Due to Pneumonia
Due to
Other Conditions congenital malformation of jaw.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury,
23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp Date signed 3-25-44

JO #37094

G 15510

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15510 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Weldon Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Steffy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1942

8. AGE: Years	Months	Days	If less than one day
1	4	3	hr min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Steffy
13. Birthplace Penn.

MOTHER
14. Maiden Name Mary Hessanuer
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3-27-44 (month) (day) (year)
(c) Cemetery or crematory Dulaney Valley Rd.
Location
18 (a) Funeral director Williams Cook Inc
(b) Address 127 W. Paul St
19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1944, at 12:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23 1944 to 3-24 1944, and that I last saw h alive on 3-24 1944.

Immediate cause of death bronchopneumonia — Duration 3 days
Due to Pertussis?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Baltimore Md. Date signed Mar 24 1944

G 15511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G 15511 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4307 Clifton

(c) Hospital or institution:

28

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 1/2 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)

(d) Street No. 4307 Clifton Blvd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Laura Edwards Lyman

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	NAE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Fred H. Lyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31st 1869

8. AGE: Years	Months	Days	If less than one day
75	4	24	hr min.

9. Birthplace Conn. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name James F. Edwards

13. Birthplace N.Y.

MOTHER

14. Maiden Name Emma A. Baker

15. Birthplace Maine

16 (a) Informant Florence E. Sumwalt

(b) Address 4307 Clifton Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)

(c) Cemetery or crematory Randolph

Location Randolph N. J.

18 (a) Funeral director William Cook Inc.

(b) Address 7 St. Paul St.

MAR 26 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1944, to March 25 1944, and that I last saw her alive on March 25 1944.

Immediate cause of death Coronary thrombosis

Duration 3 days

Due to arteriosclerosis —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry D. McCarty M. D.

Address 87 W Preston St Date signed 3/26/44

G 15512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15512 Registered No. 452

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 552 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Reese

3 (b) If veteran, name war: N
3 (c) Social Security Account No. NONE

4. Sex: Male
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Nellie V. Reese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1st 1865

8. AGE: Years 79 | Months 1 | Days 24 | If less than one day: hr min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Barber
11. Industry or business Self

FATHER
12. Name Peter Reese
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant C. C. Reese
(b) Address 552 Belona Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3-31-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Holt
(b) Address 125 S. Paca St

19 (a) (Date received by local registrar) MAR 26 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 25th 1944 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 44 to Mar 25 19 44 and that I last saw him alive on Mar 25 19 44.

Immediate cause of death: Carcinoma of tongue — Duration: 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Schulz
Address 2301 Annapolis Rd Date signed 3/25/44

G 15513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G 15513 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 327 N. Monastery Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 7
(e) Length of stay in Baltimore (yrs., mos., or days) 54 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Nixon

3 (b) If veteran, name war —
3 (c) Social Security Account No. — — —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ George E. Nixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8th 1874

8. AGE: Years	Months	Days	If less than one day
54	6	16	hr min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name George Fowler
13. Birthplace Ireland

MOTHER
14. Maiden Name Nora "
15. Birthplace "

16 (a) Informant Margaret Evans
(b) Address 327 Monastery Ave

17 (a) Burial (b) Date thereof 3-28-44 (month) (day) (year)
(c) Cemetery Catholic
Location Balto. Md.

18 (a) Funeral director William Cook Jr
(b) Address 1217 St. Paul St

19 (a) MAR 26 1944 (Date rec'd by registrar) (b) Hunting for Williams M.P. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24th 1944 at 2:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1943 to March 24 1943. and that I last saw her alive on March 22 1943.

Immediate cause of death Respiratory failure — Duration 48 hours.

Due to Carcinoma of breast with generalized metastasis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard Zappe
Address 3101 Calvert Date signed 3/25/44

G 15514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 162 W. Hamburg
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 162 W. Hamburg (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minerva Witherspoon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife Harold Witherspoon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1912

8. AGE: Years	Months	Days	If less than one day
32	—	—	hr. min

9. Birthplace John Island. S.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daymon Taylor
13. Birthplace S.C.

MOTHER
14. Maiden Name Nellie
15. Birthplace S.C.

16 (a) Informant Harold Witherspoon
(b) Address 162 w Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 27-44 (month) (day) (year)
(c) Cemetery or crematory Charleston
Location South Carolina

18 (a) Funeral director James A Davis
(b) Address 142 Wolfe St

(c) Registrar (b) Huntington Williams, M.D. Registrar

MAR 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 24 1944 at 6 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/1944 to 3/24/1944 and that I last saw her alive on 3/24/1944

Immediate cause of death Pneumonia — Duration 5 Days

Due to

Due to

Other Conditions Pleurisy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Taylor M. D.
Address 622 Hasledon Ave Date signed 3/25/44

G 15515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15515 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 Light St
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 E Barney St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Nelson Towers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Viola C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/26/1876

8. AGE: Years	Months	Days	If less than one day
67 76	11	26	hr. min.

9. Birthplace Talbot Co Md (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Nathaniel Potter Towers

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth A Moore

15. Birthplace England

16 (a) Informant Mrs Viola C Towers

(b) Address 218 E Barney St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28/44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location 2330 Gardenia Ave

18 (a) Funeral director William M Marech

Address 1345 Light St

MAR 26 1944

19 (a) (Date rec'd by registrar) Hunting for William Murphy

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 19 44 to Mar 23 1944, and that I last saw h[illegible] alive on Mar 23 19 44.

Immediate cause of death Apoplexy due to cerebral hemorrhage — Duration

Due to

Due to

Other Conditions Hypertension C-V disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Lukato M. D.

Address 210 Light St Date signed Mar. 23/44

G 15516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15516 Registered No. 1131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 N East Ave
(c) Hospital or institution: 26 LD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Yetta Gleiman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Simon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Isidor Kirshbaum
13. Birthplace Russia

MOTHER
14. Maiden Name Eva ?
15. Birthplace Russia

16 (a) Informant Simon Gleiman
(b) Address 11 N East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

MAR 26 1944 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1944, at 8.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to 3/23 1944.
and that I last saw h alive on 3/23 1944.

Immediate cause of death: General Arteriosclerosis — Duration 5 yrs
Due to Chronic Nephritis — Duration 5 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Meyer L. Solomon
Address 129 S. Broadway Date signed 3/27/44

G 15517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G 15517 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 N. Belnord Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 704 N. Belnord Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Kreiner

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Tauber
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1879

8. AGE: Years	Months	Days	If less than one day
65 ~~65~~	2	6	hr. min

9. Birthplace Hungaria (Town, county, and state)
10. Usual Occupation mill wright
11. Industry or business Egest Band (Cuts Bay

FATHER
12. Name Elias Kreiner
13. Birthplace Hungaria

MOTHER
14. Maiden Name Mary ?
15. Birthplace Hungaria

16 (a) Informant Mary Kreiner
(b) Address 704 N. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beloit Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address 1600 Gardner Ann Sts.

MAR 26 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944 at 4:28 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1944 to March 24 1944, and that I last saw him alive on March 23 1944.

Immediate cause of death: Carcinoma of stomach. — Duration: 2 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 701 N. Belnord Ave. Date signed 3/24/44

Schmitz

448779
G 15518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15518
124a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town Benedict (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Thomas
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-16-15
8. AGE: Years 28 Months 8 Days 9 If less than one day hr min.
9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business
MOTHER / FATHER
12. Name Henry Crisco
13. Birthplace N.C.
MOTHER
14. Maiden Name Ardie Spencer
15. Birthplace N.C.
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-44 (month) (day) (year)
(c) Cemetery or crematory High Point n e.
Location n. c.
18 (a) Funeral director George H. Kelson
(b) Address 1303 Presstman ST
19 (a) Huntington Williams, M.D. (Date) (Signature of registrar)
MAR 26 1944
VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 25 1944, at 445 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1944, to MAR 25 1944, and that I last saw her alive on MAR 25 1944.

Immediate cause of death: Respiratory failure — Duration: 2 yrs
Due to Cerrhosis of Liver — 2 yrs
Due to Alcohol
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address Johns Hopkins Hosp Date signed 3-25-44

G 15519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15519 Registered No. 1218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished if the facts are known. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 Roberts Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 556 Roberts Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Will Jackson
13. Birthplace Ga

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Ella Jones
(b) Address 556 Robert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (month) (day) (year)
(c) Cemetery or crematory Tacoma Ga
Location Ga

18 (a) Funeral director George S. Kelson
(b) Address 1303 Pressstman St

19 (a) 3-28-1944 (Date received by Registrar) (b) Registrar

Huntington Hillsboro Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23-1944, at 10:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Chronic Glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Thalheimer M.D.
Medical Examiner.
Date signed 3-24-44

G 15520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15520 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2929 St. Paul (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Dalton E. Warfield
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr	min
73				

9. Birthplace Md. (Town, county and state)
10. Usual Occupation Clerk, U.S.C.
11. Industry or business

FATHER
12. Name Nathan O. Warfield
13. Birthplace Md.

MOTHER
14. Maiden Name Laura V. Day
15. Birthplace Md.

16 (a) Informant Mrs Margaret V. Warfield
(b) Address 2929 St Paul St.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof March 27/44 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location 2801 Frederick ave

18 (a) Funeral director John Dudrow Sons
(b) Address 1900 Eutaw Place Huntingtown Williams, Md.

19 (a) 3-26 1944 (Registrar) (b) Registered

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944 at 9 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 19 . to 3-24 . 1944
and that I last saw him alive on 3-24 1944

Immediate cause of death Pneumonia — **Duration**

Due to Generalized Arteriosclerosis resulting in Thrombophlebitis

Due to and Varicose Ulcer followed by Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
(f) Signature [illegible]
Address St. Agnes Hospital Date signed 3/24/44

PHYSICIAN
Underline the cause to which death should be charged statistically

G 15521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Genl Hosp.
(d) Length of stay in hospital or inst. yrs., mos., or days 7 days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RFD, and name town)
(d) Street No. 3102 Hilton St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Adelbert W. Mears
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Ellen C. Emmert
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr Feb 8 1870
8. AGE: Years 74 Months 1 Days 15 If less than one day hr min
9. Birthplace Eastern Shore Md. Va (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Wm A. P. Mears
13. Birthplace Va

MOTHER
14. Maiden Name Susan Beloate
15. Birthplace Va

16 (a) Informant Mrs. A. W. Mears
(b) Address 3102 N. Hilton St.
17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Mch 27/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick ave.
18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place
19 Mar 26 1944 Huntington Williams M.D. (Date) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1944, at 10 15 P.M
21. I certify that death occurred on the date above stated, that I attended deceased from 3/17 1944, to 3/23 1944, and that I last saw him alive on 3/23 1944.

Immediate cause of death
Cardio-renal failure — Duration: 5 days
Due to P.O. prostatectomy
Due to
Other Conditions
Uremia
(Include pregnancy within 3 months of death)
Date of operation 3/18/44
Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically

23. Signature H. W. Haynes M. D.
Address Md. Genl Hosp Date signed 3/23/44

(OVER)

C 15522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 15522 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 1/2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (25)
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3905 Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. M. Roy Greaver
3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mrs. Mary Greaver
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): Feb. 28, 1874
8. AGE: Years: 70 Months: 0 Days: 25 (27) If less than one day: hr min
9. Birthplace: Bethlehem, Va. (Town, county and state)
10. Usual Occupation: —
11. Industry or business: —

MOTHER / FATHER
12. Name: not obtained / James Greaver
13. Birthplace: Va
14. Maiden Name: not obtained / August Gayhart
15. Birthplace: Va.

16 (a) Informant: Father Halbert
(b) Address: All Saints Chapel (Curtis 1716)
17 (a) Burial, cremation, or removal: Burial (b) Date thereof: 3/28/44 (month) (day) (year)
(c) Cemetery or crematory: Edgehill Cem.
Location: Charlestown, West Va
18 (a) Funeral director: John F. Cowan & Son
(b) Address: 901-03 Hollins Street.
19 (a) [illegible] (b) Huntington, W. Va.
MAR 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/44 19 , at 2:30 A. M.
21. I certify that death occurred on the date above stated, that I attended deceased from 3/23/44 to 3/25/44, and that I last saw h[illegible] alive on 3/25/44
Immediate cause of death: Pneumonia
Due to: Cardiac failure (?)
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: L.D. Greaberg
Address: Church Home & Hospital Date signed: 3/26/44 (M. D.)

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 15523

15523

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument Street
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
City or town Baltimore.
(If outside city or town limits, write RURAL and name town)
(c) Street No. 2427 Eastern Ave.
(If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbert J. Finneran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Wh

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Sarah E. Finneran

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Aug 16, 1904.

8. AGE: Years 39 Months 7 Days 9 If less than one day hr min

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Beth Steel Co.

FATHER
12. Name William H. Finneran
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Lina Massal
15. Birthplace Balt Md

16 (a) Informant Mrs Sarah E. Finneran
(b) Address 2427 Eastern Ave City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (Month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director John F. Cowan & Son
(b) Address 901 Baltimore Street

19 (a) MAR 27 1944 (Date rec'd by registrar) (b) Interring or Cremating

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944 at 1:05 M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 25 1944 to March 25 1944 and that I last saw h im alive on March 25, 1944

Immediate cause of death Uremia — Duration

Due to Malignant nephrosclerosis

Due to

Other Conditions
(Include pregnancy within 3 month of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Murray L. Jenner
Address Sinai Hosp Date signed 3/25/44 M D

PHYSICIAN
Underline the cause to which death should be charged statistically

G 15524 ✓ G15528 G 15524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 92a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1625 Westwood Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a State Md. b County

c City or town Baltimore (If outside city or town limits, write RFD and give town)

d Street No. 1625 Westwood Ave. (If rural, give location)

e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin C. Langston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1882

8. AGE: Years 62 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Hailer

11. Industry or business

FATHER 12. Name James Langston

13. Birthplace Nash, No. C.

MOTHER 14. Maiden Name Isabell Fillians

15. Birthplace Clarksville Va.

16 (a) Informant Mary C. Langston

(b) Address 1625 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md.

18 (a) Funeral director Mrs. Lyo. St. Holland

(b) Address 1681 Druid Hill Ave

19 (a) Date received by registrar MAR 27 1944 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1944 to March 23 1944 and that I last saw h alive on 3/23 1944

Immediate cause of death A. M. S. Hemorrhagic Stroke — Duration: 2 hrs

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature B. N. Fletcher M. D.

Address 1715 Linden Ave Date signed 3/26/44

B 15525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 P

V B 15525

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 15 W 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3724 Towanda Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hanna Malinow
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced W
6 (b) Name of husband or wife Samuel D.
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr
8. AGE: Years 59 Months Days If less than one day hr min

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-44 (month) (day) (year)
(c) Cemetery or crematory Wash. Rd. Silver Spring Rd.
Location
18 (a) Funeral director Jack Levin
(b) Address 1439 E. Balto St

19 (a) (b) Registrar

MAR 27 1944
VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1944, at 6:00A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/7 1944, to 3/26 1944, and that I last saw h[illegible] alive on 3/26 1944.

Immediate cause of death: Respiratory Failure — Duration

Due to Cerebral vascular accident

Due to

Other Conditions Cirrhosis of liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adyan S. Bonick
Address Sinai Hosp. Date signed 3/26/44

G 15526

JO #86843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

42D

G 15526
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 N. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward [illegible] Wantke
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1873
8. AGE: Years 70 | Months 6 | Days 16 | If less than one day: hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Herman [illegible] Wantke
13. Birthplace Germany

MOTHER
14. Maiden Name Henriette Schreiber
15. Birthplace Germany

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004-08 Orleans St.

MAR 27 1944 (Date rec'd by Registrar)
(b) [illegible] Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1944, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1944 to 3/24 1944.
and that I last saw h[illegible] alive on 3/24 1944.

Immediate cause of death
Pneumonia
Duration 2 wks
Due to Benign prostatic hypertrophy with urinary retention
Due to Hypertensive cardiovascular disease
Other Conditions Emphysema
(Including pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mathe M D
Address B-C-H Date signed 3/24/44

G 15527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 R

Registered No. G 15527

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-1
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(c) Street No. 2022 E. Monument St
(If rural, give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEIGER, JOSEPH
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife Margaret Geiger
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr)
8. AGE: Years 70 Months 6 Days 7 If less than one day hr min
9. Birthplace MD (Town, county, and state)
10. Usual Occupation RETIRED POLICEMAN
11. Industry or business

FATHER
12. Name GEORGE GEIGER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARGARET SCHLACK
15. Birthplace GERMANY

16 (a) Informant Beards
(b) Address JOHNS HOPKINS HOSP

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

MAR 27 1944
(Date received by registrar)

(b) Limestone Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1944, at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 6 1944 to MARCH 22 1944.
and that I last saw him alive on MARCH 22 1944

Immediate cause of death Cardiac failure — Duration

Due to Carcinoma of Urinary bladder with metastases.

Due to Urinary tract Infection Bilateral hydronephrosis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature Russell B. Roth M.D.
Address Johns Hopkins Hosp Date signed 3/29/44

G 15528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15528 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bellona and Belvedere Aves.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5317 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank C. Seaby

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Married

6 (b) Name of husband or wife Hermina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1890

8. AGE: Years	Months	Days	If less than one day
54		15	hr. min

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Foreman-Beth. Steel Co.
11. Industry or business

FATHER
12. Name Gregory Seaby
13. Birthplace Austria

MOTHER
14. Maiden Name Caroline Petras
15. Birthplace Austria

16 (a) Informant Mrs. Hermina Seaby
(b) Address 5317 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto., Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004-08 Orleans St.

19 (c) Date received by registrar MAR 27 1944 Hunter for Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1944, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1943 to 3/24 1944, and that I last saw h[illegible] alive on 3/11 1944

Immediate cause of death Cerebral Thrombosis

Due to General Art. Sclerosis

Due to

Other Conditions Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 8/1/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature S. M. Greenberg M. D.
Address 613 Eastern Ave. Date signed 3/25
S. M. Greenberg

15529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15529
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 E. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Wiedenhoft (Wiedenhoeft)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Herman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1860

8. AGE: Years	Months	Days	If less than one day
84	2	5	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ---
13. Birthplace Germany

MOTHER
14. Maiden Name ---
15. Birthplace Germany

16 (a) Informant Mrs, Augusta Steimetz
(b) Address 2209 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory First Un. Ev. Cem.
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004-08 Orleans St.

MAR 27 1944 (Registrar's signature) (b) Huntington Williams, M.D. (Physician)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to March 24 1944, and that I last saw alive on March 23 1944

Immediate cause of death: Subarachnoid Hemorrhage — Duration 3 days
Due to Cerebral Arterio-Sclerosis — ?
Due to Cardiac Catastrophe Atlantic — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mark F. Douglas, M. D.
Address 500 E. Fayette Date signed 3/28/44

G 15530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15530
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 Kildare Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Kildare Drive
(Or other location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard J. Chenoweth

3 (b) If veteran, name war: Spanish American

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rose H.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) June 6, 1880

8. AGE: Years 63 | Months 9 | Days 18 | If less than one day: hr. min.

9. Birthplace Baltimore County, Maryland
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Self

FATHER
12. Name William Chenoweth
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Susan R. Devese
15. Birthplace Baltimore County, Md.

16 (a) Informant Rose H. Chenoweth
(b) Address 2917 Kildare Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29, '44 (month) (day) (year)

(c) Cemetery or crematory National Baltimore
Location 5501 Frederick Avenue

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 MAR 27 1944 (b) Limitation for Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944, at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to March 24 1944 and that I last saw h[illegible] alive on March 24 1944.

Immediate cause of death: Cardiac Decompensation — Duration 1 day

Due to: Valvular Heart Disease — 5 yrs

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3/26/44

VS 180

15531

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15531
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 E Montgomery St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 E Montgomery St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Flot

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1852

8. AGE: Years 91 | Months 3 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Henry Flot
(b) Address 318 N Bloomingdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Tilford & Sons
(b) Address 1219 E Fayette St

MAR 27 1944
(Date rec'd by Registrar) (by) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1944 to Mar 23 1944 and that I last saw h[illegible] alive on Mar 23 1944

Immediate cause of death	Duration
Cardiac Hemorrhage	3 hrs
Due to Senile Dementia	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Dawson M.D.
Address 1 Bloomfield St Date signed 3/24/44

G 15532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G 15532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Pumphrey Ave.
(Rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lona White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
Female	White	Divorced

6 (b) Name of husband ~~or wife~~ John H. White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15½ - 1878

8. AGE: Years	Months	Days	If less than one day
Abt. 65	5	10	hr. min.

9. Birthplace Manassas Co. Va.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business Self

FATHER
12. Name Robert E. Lee
13. Birthplace Va

MOTHER
14. Maiden Name Melissa Maxfield
15. Birthplace Va.

16 (a) Informant Mrs. Pauline Welch
(b) Address 607 S. Pumphrey Ave

17 (a) Burial (b) Date thereof 3/27/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Mathews Funeral Home
(b) Address 1219 Pennsylvania Ave Huntingdon Williamsport, Md.

19 (a) MAR 27 1944 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25-44 19 . at 3:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21-44 19 . to 3-25-44 19 . and that I last saw her alive on 3-25-44 19 .

Immediate cause of death	Duration
[redacted] Intestinal Obstruction	4 days
Due to Plastic Peritonitis	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Plastic Peritonitis 2° Intest. Obstr.

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius Gstuck M. D.
Address Franklin Square Hosp. Date signed 3-25-44

VS 2

G 15533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

Registered No. G 15533

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Lyndhurst Ave.
(c) Hospital or institution:

15 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Lyndhurst Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Sheets

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John M. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14,1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
68	10	10		

9. Birthplace Oblong, Ill (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name (Unknown)
13. Birthplace Ill

MOTHER
14. Maiden Name Unknown
15. Birthplace Ill

16 (a) Informant Capt. John B. Sheets
(b) Address 2903 Lyndhurst Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Oblong
Location Oblong, Ill

18 (a) Funeral director William Loyd Inc
(b) Address 1217 E Fayette St

19 (a) MAR 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to March 24, 1944, and that I last saw him alive on 3-24-1944.

Immediate cause of death Carcinoma of Uterus

Duration

Due to

Due to

Other Conditions Carcinoma of Stomach (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Vogt M. D.
Address 826 Woodlawn Ave Date signed 3/25/44

G 15534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G 15534 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAMBETH B HENDERSON

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 238-09-9441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	W	Married

6 (b) Name of husband or wife Lucile Margie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 1884

8. AGE: Years	Months	Days	If less than one day
52	5	27	hr. min.

9. Birthplace New York Lowville NY (Town, county, and state)
10. Usual Occupation Machinist helper
11. Industry or business Baltimore Shipbuilding & D

FATHER
12. Name Ben Henderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Ann Unknown
15. Birthplace "

16 (a) Informant Lucile Henderson
(b) Address 626 W Balto St

17 (a) Linwood (b) Date thereof 3/29/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Concord
Location Oneida & Fleet Sts

18 (a) Funeral director Wilson Corkran
(b) Address 1219 E Fayette St

19 MAR 27 1944 (Date rec'd by registrar) Huntington Williams MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 1944, at 4 25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carbon monoxide poisoning
Due to Suicide

Other Conditions mental depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-24-44 at M.
(b) Where did injury occur? at home address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Gas - Coal - illuminating gas

23. Signature H. L. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 3-25-44

VS 151

G 15535

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 15535 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 Linden Ave
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Chideckel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Dr. Maurice Chideckel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Amarupto Hagge
13. Birthplace Russia

MOTHER
14. Maiden Name Witte
15. Birthplace Austria

16 (a) Informant Dr. Maurice Chideckel
(b) Address 2225 Linden Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3- (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location Sherman Hill Rd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 MAR 27 1944 Huntington Williams, M.D. Registrar
(Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-44 19 , at 12 05 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26-44 19 to 19
and that I last saw h alive on 19

Immediate cause of death
Acute Coronary Thrombosis

Due to Coronary Artery Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Sudden
Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Meta M. Stark
Address 2904 Rexter Rd Date signed

15536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15536 Registered No.

§3a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Linden Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Linden Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hoston Logan Carter
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M-Wid
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1902
8. AGE: Years 59 | Months | Days | If less than one day hr. min.
9. Birthplace Florida (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Athena Smith
(b) Address 1015 Linden Av friend
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn
18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St
19 (a) (Date rec'd by registrar) MAR 27 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944 at 6.25 P M
21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1944 to March 24 1944 and that I last saw h[illegible] alive on March 24 1944.

Immediate cause of death: Cerebral hemorrhage — Duration 18 hr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1463 N Carey St Date signed 3/28/44

G 15537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

G 15537 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4641 Marble Hall Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4641 Marble Hall Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Gettermann

3 (b) If veteran, name war --

3 (c) Social Security Account No. 219-03-7574

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nettie M. Gettermann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 20, 1894

8. AGE: Years	Months	Days	If less than one day
49	11	3	hr. min.

9. Birthplace Baltimore Co., Md. (Town or county, state or country)
10. Usual Occupation Deputy Collector Internal Revenue
11. Industry or business Custom House

FATHER
12. Name George L. Gettermann
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine G. Ellenberger
15. Birthplace Germany

16 (a) Informant Mrs. Nettie M. Gettermann
(b) Address 4641 Marble Hall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 27, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave., Balto., Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1944 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to March 23 1944, and that I last saw h alive on March 23 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration 8 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter E. Krug M. D.
Address 26 Medical Bldg Date signed 3/25/44

G 15538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G 15538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 892 W. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Thompson

3 (b) If veteran, name war: 1st World War

3 (c) Social Security Account No. No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Frank Thompson
13. Birthplace St. Louis Mo.

MOTHER
14. Maiden Name Mary Heffner
15. Birthplace ?

16 (a) Informant Mr. John W. Thompson
(b) Address 3065 Overland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Federal Rd.

18 (a) Funeral director J. Heiman & Son
(b) Address 32 S. Broadway.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MAR 27 1944

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1944, at 4 A. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis; Tuberculous cavities, bilateral

Due to

Other Conditions Cirrhosis of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 24, 1944.

G 15539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G 15539 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4149 Fairview ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Grossfeld

3 (b) If veteran, name war	3 (c) Social Security Account No. 216-05-8881

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Clara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1895

8. AGE: Years	Months	Days	If less than one day hr.	min.
48	7	1		

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business Manager

FATHER
12. Name Meyer Grossfeld
13. Birthplace Poland

MOTHER
14. Maiden Name Chandel Zucker
15. Birthplace Poland

16 (a) Informant Louis Grossfeld
(b) Address 4149 Fairview ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location Hamilton ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address MAR 27 1944 26 W Monument ave Huntington Williams, M.D.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-44 19 . at 8:02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2/44 19 . to 3/26 1944, and that I last saw him alive on 3-25 1944.

Immediate cause of death: respiratory failure — Duration

Due to cardiac

Due to Carcinoma (site not definite yet)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of stomach near (? Stomach or pancreas ?)

of autopsy: Gall bladder pancreas ?)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Lebendis
Address Sinai Hospital Date signed 3/24/44 M. D.

VS 160

15540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

✓ G 15540
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 N. Glover Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N Glover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert C. Roppelt

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Feb. 26 - 1944

8. AGE: Years	Months	Days	If less than one day
	1	-	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Frank Roppelt
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anthonet Mazan
15. Birthplace Baltimore

16 (a) Informant Frank Roppelt
(b) Address 15 N. Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 27/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

19 MAR 27 1944 (Date rec'd by Registrar) Interring for Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 26 - 1944, at 9 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Congenital Hydrocephalus

Due to

Other Conditions Central Cleft Palate,
Bi-lateral club Feet.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wilson M.D.
Medical Examiner.
Date signed 3-26-44

G 15541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15541 Registered No. 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.M.H. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Carter.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-44

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace U.M.H. - Balto, Md. (Town, county, and state)
10. Usual Occupation — Infant.
11. Industry or business

FATHER
12. Name Mr. Charles Carter
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mrs. Margaret [illegible]
15. Birthplace Maryland.

16 (a) Informant
(b) Address Hospital.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Jessops
Location Sparks, Md.
18 (a) Funeral director Landon M. Bruffs
(b) Address Sparks, Md.

MAR 27 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1944 at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1944 to 3-27 1944 and that I last saw h i m alive on 3-27 1944.

Immediate cause of death Atelectasis left lung.

Due to Prematurity.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Monroe M. D.
Address U M H. Date signed 3-25-44

G 15542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 15542

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 E. 20th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 E. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZA M. WALKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1847

8. AGE: Years	Months	Days	If less than one day
96	6	15	hr min.

9. Birthplace Cornersville, Dorchester Co., Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Lambdin
13. Birthplace Cornersville, Dorchester Co. Md

MOTHER
14. Maiden Name Jane Beakwith
15. Birthplace Dorchester Co., Md.

16 (a) Informant Mrs. Roberta W. Bateman
(b) Address 322 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/ 1944, at 3:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 44 to 3/26 1944, and that I last saw her alive on 3/26/ 1944.

Immediate cause of death: Myocarditis Arteriosclerosis — Duration: Gradual

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. Handy M.D.
Address 140 Park Ave. Date signed 3/27/44

HEALTH DEPARTMENT—CITY OF BALTIMORE

15543 15543

CERTIFICATE OF DEATH

74a

PLACE OF DEATH
CITY OF BALTIMORE: (No. Dr. Beck Hosp. 100 E. 23rd St. St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME CATHERINE JOSEPHINE ZEPP

If U. S. Veteran specify WAR

(a) Residence: No. 607 E. 33rd St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Simon J.

6. DATE OF BIRTH (month, day, year) July 2, 1875

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	8	24	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto., Md.

FATHER
13. NAME Gregory Frederick Behn
14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER
15. MAIDEN NAME --
16. BIRTHPLACE (city or town) (State or country) --

17. INFORMANT Mrs. Warren Eckman
(Address) 607 E. 33rd St.

18. BURIAL, ~~CREMATION, OR REMOVAL~~
Place Balto. Cem. Date 3/29/44 19

19. UNDERTAKER WM. J. TICKNER & SONS
(Address) Balto., Md.

20. FILED ..... 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 26 1944

22. I HEREBY CERTIFY, That I attended deceased from Feb 3 1944 to March 26 1944

I last saw her alive on March 26 1944 Death is said to have occurred on the date stated above, at 9:45 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	3/21/44
Chronic lymphatic leukemia	?

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify

(Signed) Louis J. Krolb M. D.
(Address) 100 E. 23rd St.

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

MAR 27 1944 Huntington Williams M.D.

G 15544

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15544 / 131a

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

12-5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 St. Paul St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME NELLIE R. GREGORY

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frank S. Gregory
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 28, 1867

8. AGE: Years	Months	Days	If less than one day
76	9	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation -- None
11. Industry or business

FATHER
12. Name William O. Stubbs
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Vansant
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Nellie R. Gregory
(b) Address 1620 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ..... (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944, at 10:55 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1942, to 3/25 1944, and that I last saw her alive on March 25 1944.

Immediate cause of death	Duration
(a) Virginia	5 days
Due to (b) Lobar Pneumonia Bronchitis	- 2 -
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Courtney Jones, M. D.
Address 8 East Read Street Date signed 3/26/44. M. D.

G 15545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15545 Registered No.

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN J. HEIL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jessie E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1889

8. AGE: Years	Months	Days	If less than one day
54	4	10	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Agent
11. Industry or business Md. S. P. & A.

FATHER
12. Name John Heil
13. Birthplace New York

MOTHER
14. Maiden Name Mary Kopriva
15. Birthplace Md.

16 (a) Informant Mrs. Jessie E. Heil
(b) Address 1525 Clifton Ave. 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1944, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 1943 to March 24, 1944 and that I last saw him alive on March 23, 1944.

Immediate cause of death
Cerebral Hemorrhage
Due to
Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1 mo.

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2372 Eastwood Pkwy Date signed 3/27/44

G 15546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15546 Registered No. 1218

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Stoddard Ct.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Stoddard Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Uriah Boswell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	married

6 (b) Name of husband or wife Belle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62				

9. Birthplace Montgomery Co. Md. (Town, county, and state)
10. Usual Occupation Laboter
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Belle Boswell
(b) Address 904 Stoddard Ct.

17 (a) Burial (b) Date thereof 3/27/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAR 27 1944 (b) Huntington Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 16 1944, to Mar 23 1944 and that I last saw h[illegible] alive on Mar 23 1944.

Immediate cause of death Chronic nephritis — Duration about one year

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Pelletier M. D.
Address 817 Hamilton Ave Date signed Mar 29 44

G 15547

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15547 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2137 Mc Henry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2137 Mc Henry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Valeria B. Fogtmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Wm H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1873

8. AGE: Years 70 | Months 5 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name — Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name — Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Olga Haus
(b) Address 2119 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Mitten
(b) Address 401 Edmondson Ave

19 (a) Huntington Williams M.D. Registrar
(b) Date received (month, day, year) MAR 27 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/44 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1944 to 3/24 1944 and that I last saw her alive on 3/21 1944.

Immediate cause of death atonia
uterine cancer
vascular disease

Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Williams M.D.

Address 316 Wilkens Ave Date signed 3/27/44

G 15548

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15548
Registered No. 1314

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Thomas Jefferson Coombs
3 (b) If veteran, name war
(c) Social Security Account No. 213-10-2561

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Jennie Kaltenhauser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/80

8. AGE: Years	Months	Days	If less than one day
64	1	11	hr min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Overlea Theatre

FATHER
12. Name John Coombs
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Hilda Coombs (daughter)
(b) Address 2233 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)
(c) Cemetery or Crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 MAR 27 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 16 1944 to Mar 25 1944 and that I last saw h / m alive on Mar 25 1944.

Immediate cause of death Congestive heart failure with terminal pneumonia — Duration

Due to Hypertensive Cardio Renal Disease

Due to Nephritis (Chronic)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J Brennan M. D.
Address St Joseph's Hospital Date signed 3-25-44

Huntington Pittsburgh, Pa.

G 15549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15549 Registered No. 131B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 Melville Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Melville Avenue (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME JOSEPHINE GLEBA

3 (b) If veteran, name war ------

3 (c) Social Security Account No. ------

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 66 | Months | Days | If less than one day: hr. min.

9. Birthplace Skapy, Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ---------- Golecki
13. Birthplace Skapy, Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. Steven Gleba
(b) Address 1924 E. 28th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern ave

19 (a) ____ (b) ____
(Date rec'd by registrar) Huntington Williams M.D.
R 2 Apr 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1944 at 1.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2, 1944 to Mar 25 1944, and that I last saw h-e alive on Mar 24, 1944.

Immediate cause of death Chr. Nephritis

Due to

Due to

Other Conditions Chr Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 820 Medical Arts Bldg Date signed 3/30/44

B 15550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

B 15550 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Idg.
(e) Length of stay in Baltimore (yrs., mos., or days) 19 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 E Fort Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Julia Anna Myer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 17th 1942

8. AGE: Years	Months	Days	If less than one day
1	7	8	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Peter Myer
13. Birthplace Poland

MOTHER 14. Maiden Name Thelma Myers
15. Birthplace Baltimore Md.

16 (a) Informant Thelma Myer
(b) Address 1106 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 28th 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location A.A. Co. Md.

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E Fort Ave

19 (a) (Signature of registrar) (b) Registrar

MAR 27 1944

VS-150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1944, at 4:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1944 to 3-25 1944, and that I last saw h[illegible] alive on 3-25 1944.

Immediate cause of death Generalized Peritonitis

Due to Perforated appendix

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation Appendectomy 3-24

Major findings of operation —

of autopsy —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Stanley R. Greenwald M.D.
Address 1213 Light St Date signed 3-25-44

G 15551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15551 Registered No.

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. Latrobe Apts. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Bernard J. Barrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	7	6.		

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Lumberman

11. Industry or business Forestmaig Lbr Co.

FATHER

12. Name James J. Barrett

13. Birthplace Ireland

MOTHER

14. Maiden Name Catherine Carroll

15. Birthplace Ireland

16 (a) Informant Hospital Record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Location Baltimore, Md.

18 (a) Funeral director H. W. Means and Son

(b) Address 505 N. Calvert St.

19 MAR 27 1944 (Date received by registrar) Hunter for Willigis Registrar

VS 180 3/27/44 Approved: Chester J. Lubinski M.D. Robert Co Foster MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1944 at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1943 to 3/25 1944, and that I last saw him alive on 3/25 1944

Immediate cause of death: a Septicemia — Duration 3 wks

Due to Fractured Hip. — Duration 5½ Mo.

Due to Fractured Hip

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/26/43

Major findings of operation: Fx. Hip

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence October 12 1944 M

(c) Where did injury occur? Latrobe Apts, Balto, Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no

(e) Means of injury Slipped and fell down stairs

23. Signature D J Barry

Address Mercy Hosp Date signed 3/27/44

G 15552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15552 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4201 Euclid ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Euclid ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E. Kassakatis

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-07-5352

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1878

8. AGE: Years	Months	Days	If less than one day
65	4	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Hopper Company

FATHER 12. Name Herman A Kassakatis

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Katharine Horz

MOTHER 15. Birthplace Germany

16 (a) Informant Miss Lena Kassakatis

(b) Address 4201 Euclid ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27, 1944 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore, Md.

18 (a) Funeral director Frederick A Cole

(b) Address 2009 W Lombard St. (Hunter for Williams, Mgr.)

19 (a) Date received by Registrar MAR 27 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944 at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1944 to 3/24 1944, and that I last saw h[illegible] alive on 3/23 19 44

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alden H Chandler, M. D.

Address 2109 Hurd Ave Date signed 3/25/44

G 15553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

Registered No. G 15553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 W. York St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES H. DOVER ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1943

8. AGE: Years	Months	Days	If less than one day
	9	21	hr. min.

9. Birthplace Knoxville Tenn (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name James Clover
13. Birthplace S. C

MOTHER
14. Maiden Name Elizabeth Jenkins
15. Birthplace N C

16 (a) Informant Elizabeth Clover (M)
(b) Address 15 W York St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/27/44 (month) (day) (year)
(c) Cemetery or crematory Marion
Location N C

18 (a) Funeral director Isaiah L. Brown
(b) Address 108 W Montgomery St Hyattsville, Md

19 (a) (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25 1944, at 3 40 P M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, lobular

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeier M.D.
Medical Examiner.
Date signed 3-25-44

G 15554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

G 15554

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 404 Annabelle Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME George Schlein

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Anna E. Schlein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1866

8. AGE: Years	Months	Days	If less than one day
77	9	14	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Gudat S. & G. Co.

FATHER 12. Name August Schlein

13. Birthplace Ger

MOTHER 14. Maiden Name Margaret Apfel

15. Birthplace Ger

16 (a) Informant Family

(b) Address 404 Annabel Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-29-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director Samuel H. McCully

(b) Address 1312 E. Fort Ave

19 (a) Date MAR 27 1944 (b) (Registrar) Thos. G. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25-44 19 , at 11.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 19 43 to 3-25 19 44, and that I last saw h/ alive on 3-25 19 44.

Immediate cause of death Bronchio-pneumonia

Due to Decay of both legs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25/6

(a) Accident, suicide, or homicide accidental

(b) Date of occurrence 11-6-43 at 8:00 P.M.

(c) Where did injury occur? Baltimore Md

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Industrial Plant While at work? Yes (Specify type of place)

(e) Means of injury Fall on floor

23. Signature Charles O. Pfeiffer M. D.

Address 1213 Light St Date signed 3-26-44

approved by Howard J. Emerson, M. D.

G 15555 485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15555
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Pr. George
(c) City or town Berwyn (If outside city or town limits, write RURAL and give town)
(d) Street No. Jones Trailer Park (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Arnold J Baker
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-44

8. AGE: Years — | Months — | Days 9 11 | If less than one day hr min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Arnold Baker
13. Birthplace Ohio

MOTHER 14. Maiden Name Norma Schaeffer
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30 44 (month) (day) (year)
(c) Cemetery or crematory Hyattsville Maryland
Location

18 (a) Funeral director Ernest G Bachmann
(b) Address Hyattsville Md.

19 MAR 27 1944 (Registrar's signature) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 26 1944, at 940 P M

21. I certify that death occurred on the date above stated, that I attended deceased from MAR 23 1944, to MAR 26 1944, and that I last saw him alive on MAR 26 1944.

Immediate cause of death: Respiratory Failure — Duration: 1 hr

Due to Tetanus

Due to Infected umbilicus

Other Conditions 1) Congenital cardiac anomaly 2) Atelectasis, multiple 3) Malformed hands & feet

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad
Address Johns Hopkins Hosp Date signed 3-26-44 M. D.

G 15556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15556 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Christian Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Levi Stacey

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 218-01-2060

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Blanche Stacey
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) February 3, 1888

8. AGE: Years	Months	Days	If less than one day
56	1	21	hr. min.

9. Birthplace Nevada, Mo
(Town, county and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name John Stacey
13. Birthplace Nevada Mo.

MOTHER
14. Maiden Name Jane Moore
15. Birthplace Nevada Mo

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28-1944 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Baltimore

18 (a) Funeral director George F. Schnaal
(b) Address 2101 Frederick Ave

19 (a) Date received by local registrar MAR 27 1944 (b) Signature and title of local registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944, at 8:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24/44 19 , to 3/25/44 19 , and that I last saw h— alive on 3/25/44

Immediate cause of death
Coronary Occlusion
Cardiac Decompensation
Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days
1 yr.
3½

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emerson H. Gladhill

Address U.S. Marine Hospital Date signed 3/26/44

15557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G 15557
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 Coldspring Lane
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 E. Coldspring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. Samuel

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Peter R. Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1875

8. AGE: Years 69 | Months 2 | Days 16 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home work

11. Industry or business at Home

FATHER
12. Name Charles J. D. Lowenstein
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth A. Brandel
15. Birthplace Germany

16 (a) Informant Mrs. John W. Rice
(b) Address 708 E. Coldspring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28/44 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location 3801 Frederick Rd

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St

19 (a) Date received by registrar 1944 (b) Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 25th, 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1944 to 3/25 1944
and that I last saw h alive on 3/25 1944

Immediate cause of death: Uremia secondary to Carcinoma of Cervix and Metastasis — Duration: 6 yr 2 wks

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H G Jones M. D.
Address 2518 N Paca St Date signed 3/26/44

15558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 15558
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 3days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 South Robinson Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "B" Rasinski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1944

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stanley Rasinski
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Kucharek
15. Birthplace Maryland

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 27 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 27 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1944, at 9.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944, to March 18 1944, and that I last saw him alive on March 18 1944.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip P. Stephen, Jr.
Address Johns Hopkins Hosp. Date signed 3/22/44

VS 180

F0824

G 16559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15559 / 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Radnor Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Baby Hooper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Sing'l

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/24/44

8. AGE: Years	Months	Days	If less than one day
—	—	2	— hr. — min.

9. Birthplace Baltimore. Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Edward Hooper

13. Birthplace Portland Oregon

MOTHER — 14. Maiden Name Elizabeth Franklin

15. Birthplace Baltimore Md

16 (a) Informant Edward Hooper

(b) Address 711 Radnor Ave

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School MAR 27 1944

Location

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAR 27 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

0823

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1944, to 3/26 1944, and that I last saw h— alive on 3/25 1944.

Immediate cause of death Premature Infant — Duration 2 days

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature H. Williams Jr. M.D.

Address 1401 Eutaw Pl Date signed 3/26/44

G 15560

JL - 83011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15560 Registered No. 132

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 22

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 13 N. Curley St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lillian Kosmicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1914

8. AGE: Years	Months	Days	If less than one day
29	5 6	5 7	hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Lagna

13. Birthplace Italy

MOTHER 14. Maiden Name Mary Avetta

15. Birthplace Italy

16 (a) Informant B. C. H. Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29 44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Frank V. Pipitone

(b) Address 2618 E. Balto St

19 (a) MAR 27 1944 Registrar

Huntington Williams, M.D

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25- 1944 at 9.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28- 1944 to 3-25 1944 and that I last saw her alive on 3-25 - 1944

Immediate cause of death: Pulmonary TBC. complicated by TB. meningitis ?

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Raniel Ehrlich

Address 4940 Eastern Ave Date signed 3-26-44 M. D.

G 15561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15561 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Beverly Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Beverly Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Alvena Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John S. Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-1866

8. AGE: Years	Months	Days	If less than one day
77	7	19	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Joseph Bregel
13. Birthplace Md

MOTHER
14. Maiden Name ? Hammil
15. Birthplace ?

16 (a) Informant Mrs. J. Richard Dorsey
(b) Address 3012 Beverly Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 2305 Harford Rd

19 (a) (b) Registrar

MAR 27 1944 Washington Williams, Jr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1934 to Mar 25 1944
and that I last saw h alive on Mar 21 1944

Immediate cause of death

Coronary Occlusion — Duration 3 hrs.

Due to Coronary disease — 6 mo.

Due to Cardio Vascular

Other Conditions diabetes — 17 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fritz J Kinzer M. D.
Address 2700 Harford Road Date signed Mch 25 1944

G 15562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15562 Registered No. 528

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 Bett St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Bett St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Mc Shane

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Catherine Jenkins Mc Shane (If alive, give age 59 years)

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1882

8. AGE: Years	Months	Days	If less than one day hr.	min.
62	1	7		

9. Birthplace Ireland. (Town, county, and state)
10. Usual Occupation Yard Foreman
11. Industry or business B & O. R.R.

FATHER	12. Name Michael Mc Shane
	13. Birthplace Ireland.
MOTHER	14. Maiden Name Brigit Butler
	15. Birthplace Ireland.

16 (a) Informant Mrs. Catherine Mc Shane
(b) Address 1627 Bett St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynning
(b) Address 1426 Fig St E.

MAR 27 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25 1944, at 11.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1944, to March 25 1944
and that I last saw h alive on March 24 1944

Immediate cause of death Suppurative Bronchitis.

Due to

Due to

Other Conditions Carcinoma bladder suprapubic
(Includes pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. G. Schmunck M. D.
Address 1357 S. Charles St Date signed 3/27/44

G 15563

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

[redacted] Registered No. G 15563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 W. 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30/44 (month) (day) (year)

(c) Cemetery or crematory Cemetery
Location Cambridge, Md.

18 (a) Funeral director Lewis H. Dyer
(b) Address Cambridge, Md.

MAR 27 1944 (Date rec'd by Registrar) (b) Huntington Williams, Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1944 at 1.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Occlusion of left coronary artery

Due to syphilitic aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 27, 1944

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15564 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 No Paca st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days) 55 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 111 No Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS FROHNAPFEL

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 213 10 8146

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 18 1885

8. AGE: Years 59 | Months 1 | Days 6 | If less than one day: hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation Cabinet-Maker

11. Industry or business

FATHER
12. Name JOHN FROHNAPEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name CAROLINE GOLDBACH
15. Birthplace GERMANY

16 (a) Informant CATHERINE PFEIFER (NEICE)
(b) Address 1208 EDISON HIGHWAY

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 28/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lillyard & Zeiler (INC)
(b) Address 403 S. WOLFE ST.

MAR 27 1944 (b) Huntingtown Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 24 1944 at 10P. M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. A. Wollenweber M.D.
for Medical Examiner.
Date signed 3-25-44

VS 151

Please write plainly, with unfading ink. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15565 Guethlein

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15565 No. 939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 Echodale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Echodale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Isabelle Guethlein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife John S
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18 1868

8. AGE: Years	Months	Days	If less than one day hr.	min.
76	21	6		

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John P Yeager
13. Birthplace Germany

MOTHER
14. Maiden Name Eva C Poppe
15. Birthplace Germany

16 (a) Informant Myrtle Guethlein
(b) Address 3607 Echodale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

(Signature of registrar) Huntington Williams, M.D. Registrar

MAR 27 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1943, to 3/24 1944, and that I last saw h alive on 3/24 1944.

Immediate cause of death Chronic Myocarditis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Byron Tolley M. D.
Address 5703 Harford Rd Date signed 3/25/44

Huntington Williams M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 15566

15566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 414 N. Lakewood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 414 N. Lakewood Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Kunkel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1861

8. AGE: Years	Months	Days	If less than one day
82	11	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Valentine Stetter

13. Birthplace Germany

MOTHER

14. Maiden Name Elizabeth Mann

15. Birthplace

16 (a) Informant Mrs. Sallie Jahns

(b) Address 414 N. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)

(c) Cemetery or crematory Schwartz's Cem.

Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2004-08 Orleans St.

19 (a) Date received by registrar MAR 27 1944 (b) Thurston Forbes Robinson, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1944, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 19 44 to Mar 24 19 44, and that I last saw h alive on Mar 24 19 44.

Immediate cause of death	Duration
Acute Cardiac Dil.	2 days
Due to	
Due to Cardio. Renal Sclerosis	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address 1502 E 32d Date signed 3/27/44 (M.D.)

G 15567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131aG 15567

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2323 Madison
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 E Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E Eliason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	widowed

6 (b) Name of husband or wife Dorothy Eliason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10 1864

8. AGE: Years	Months	Days	If less than one day
80	2	13	hr. min

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation City Street Cleaning Pensioned
11. Industry or business

FATHER
12. Name Andrew Eliason
13. Birthplace Balto

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant James E Eliason Jr
(b) Address 2323 Madison St Balto

17 (a) (Burial, cremation, or removal) (b) Date thereof Mar 29/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Uelzmann Funeral Home
(b) Address 2008 Orleans St

19 Mar 27 1944 Huntington Milwaukee, Wis
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1944, to 3/25 1944, and that I last saw h[illegible] alive on 3/25 1944.

Immediate cause of death Hypertensive Cardio Vascular Renal Disease — Duration 7 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny, M. D.
Address 2220 E Madison St Date signed 3/27/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

KOSYJANA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15568 Registered No.

G 15568

157 M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County Md.
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4849 Lake Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Kosyjana
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 3 | Days | If less than one day hr. min

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Walter F Kosyjana
13. Birthplace Balto Md.

MOTHER 14. Maiden Name Bernadette M. Singman
15. Birthplace Baltimore, Md

16 (a) Informant Bernadette Singman
(b) Address 4849 Lake Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28 1944 (month) (day) (year)
(c) Cemetery or crematory Edmondson Cemetery
Location —

18 (a) Funeral director Wayne Whitford
(b) Address 201 E. 22nd St.

19 MAR 28 1944 Huntingtown Williams, Md.
(Date accepted for burial) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1944 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1944 to 3-26 1944, and that I last saw him alive on 3-26 1944.

Immediate cause of death
Respiratory collapse
Pulmonary Edema
Due to Congenital abnormality of the Duct. arteriosus, pulmonary s. l.
Due to obstruction.

Duration

Other Conditions Persistent Vomiting
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically

23. Signature [redacted] M. Jones Jr. M. D.
Address Univ. Hosp. Date signed 3-27-44

G 15569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

Registered No. G 15569

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1816 Park Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a State Md. b County

c City or town Balto.
(If outside city or town limits, write RURAL and give town)

d Street No. 1816 Park Ave.
(If rural give location)

e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H. McAULIFFE

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Ann Pa. McAuliffe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/31/1861

8. AGE: Years	Months	Days	If less than one day
82	6	23	hr. min.

9. Birthplace Enfield, N. C.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John P. McAuliffe

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name Ann Bottom

MOTHER 15. Birthplace Va.

16 (a) Informant Miss Agatha McAuliffe

(b) Address 1816 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) MAR 28 1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/ 1944 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1944 to 3/24 1944.
and that I last saw him alive on 3/24 1944.

Immediate cause of death
meaning

Due to Cardio Renal

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
yrs
10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John T. O'Hara M.D.

Address 86 Cathedral St. Date signed 3/27/44

John T. O'HARA

C 15570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111a

Registered No. C 15570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601½ Evesham Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Daniel Harrington Flynn, Jr.

3 (b) If veteran, name war World War II

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dorothy E. (Wood)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1915

8. AGE: Years 28 | Months 4 | Days 24 | If less than one day: hr. min.

9. Birthplace Balto County, Md. (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

FATHER
12. Name Daniel H. Flynn, Sr.
13. Birthplace

MOTHER
14. Maiden Name Haskell (Annie Haskell)
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Dorothy E. Flynn,
(b) Address 601½ Evesham Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3/28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) **(b)** Huntingtown, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-44 19 , at 1.05 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 3-16-44 19 to 3-26-44 19 , and that I last saw h[illegible] alive on 3-26-44 19 .

Immediate cause of death
Pulmonary Infarct
Due to Embolism
Due to
Other Conditions Previous Pulmonary Infarct & Secondary Infection
(Include pregnancy within 3 months of death)

Duration
5 minutes
12 days

Major findings:
Of operations
Of autopsy

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Black M. D.
Address Franklin Square Hosp. Date signed 3-27-44

VS 2

G 15571

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

G 15571
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 Callow Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 2115 Callow Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Goldberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day hr min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ✓
13. Birthplace Lith

MOTHER
14. Maiden Name ✓
15. Birthplace Lith

16 (a) Informant Harry Goldberg
(b) Address 2115 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Balto Co Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis
(b) Address 1439 E. Balto St

19 MAR 25 1944 (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1944 at 8:52 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27, 1943 to Mar 27, 1944, and that I last saw h[illegible] alive on Mar 27, 1944.

Immediate cause of death Carcinatosis — Duration 8 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 7, 1943

Major findings of operation: Carcinatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N B Lewis MD

Address 211 W. Monument St Date signed 3/27/44

3

G 15572 YAFFE ✓ G 15572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Clifton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary Sarah Yaffe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widows

6 (b) Name of husband or wife Maird Yaffe
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day hr.	min.
71				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Chaikew
13. Birthplace Russia

MOTHER
14. Maiden Name Esther —
15. Birthplace Russia

16 (a) Informant Louis Yaffe
(b) Address 2106 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location .....

18 (a) Funeral director Jack Levin Inc
(b) Address 143 E. Baltimore St

19 (a) [illegible] (b) .....
(Filled in by registrar)
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-44 19 .. at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1943 to 3/26 1944 and that I last saw h[illegible] alive on 3/26 1944

Immediate cause of death	Duration
Ch myocarditis	
acute Cardiac Collapse	
Due to	
Due to Ch Nephritis	
Other Conditions Generalized	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. H. Hornstein M. D.
Address 733 Argonne Dr Date signed 3/27/44

G 15573

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15573 ✓ 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Harford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Glenmore Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Plowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elmer F. Plowman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14. 1882

8. AGE: Years 61 | Months 6 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Julius Zippling
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Elmer F. Plowman
(b) Address 4400 Glenmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)

(c) Cemetery or crematory Moreland Park
Location Parkville, Maryland

18 (a) Funeral director Lucas Funeral Home
(b) Address 7401 Belair Road

19 (a) MAR 29 1944 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25. 1944 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1937 to 3-25 1944 and that I last saw h[illegible] alive on 3-25 1944.

	Duration
Immediate cause of death: Cerebral Thrombosis	6 days
Due to: Arterial Hypertension	10 Years
Due to: Arteriosclerosis	"
Due to:	
Other Conditions: Myocardial Degeneration, Right Hemiplegia 4 Yrs	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 63 E Belair Rd Date signed 3/27/44 M. D.

Plumbing for Williams M.D.

G 15574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1927

G 15574

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 Coldspring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Coldspring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irvin W. Shearer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widower.

6 (b) Name of husband or wife: Mary J. Shearer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): March 6, 1868

8. AGE: Years 76 | Months - | Days 20 | If less than one day ... hr. ... min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Farm Hand

FATHER
12. Name: William Shearer
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Elgin A. Shearer
(b) Address: 1302 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 29/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~: St Peter's
Location: Balto Co Md

18 (a) Funeral director: Edmond A Donovan
(b) Address: 3615-17 Eastern Ave

19 (a) ... (Date received by registrar) (b) ... Registrar

MAR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1944, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 27, 1944

The ... information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C 15575

C 15575

1152

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3733 Elm Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3733 Elm Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Earl F. Brown.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-01-6323

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married.

6 (b) Name of husband or wife Florence Brown
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) May 26, 1907

8. AGE: Years	Months	Days	If less than one day: hr.	min.
36	9	29		

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Returning Dept
11. Industry or business Edward L. Martin Co.

FATHER
12. Name Charles A. Brown
13. Birthplace Maryland.

MOTHER
14. Maiden Name Edna M. Chaney.
15. Birthplace Maryland

16 (a) Informant Florence Brown
(b) Address 3733 Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Thanowitz & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MAR 28 1944
Vs 110

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1944 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 8 1943 to May 26 1944, and that I last saw him alive on May 24 1944.

Immediate cause of death: Cardiac Decompensation — Duration 4 mos.
Due to Renal-vascular disease + Hypertension — 7 yrs.
Due to Rheumatic + peptic sore throat
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jean Dulebohn
Address 8 Apt 3 0787. Date signed 3/27/44
Helen VonTrease

G 15576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G 15576 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution: Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt. (If outside city or town limits, write RURAL and give town)

(d) Street No. 836 W. 32nd Street (If rural give location)

(e) Citizen of foreign country? O (Yes or No)

If yes, name country

3 (a) FULL NAME Myrtle E. Mrs. ~~Charles Percy~~ Jewell

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife Charles Percy Jewell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1904

8. AGE: Years	Months	Days	If less than one day
39	3 4	28 3	hr. min

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Reese

13. Birthplace Virginia

MOTHER 14. Maiden Name Bertha Whitesid

15. Birthplace Virginia

16 (a) Informant Husband

(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 29/44 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Mouland Park

Location Taylor Ave.

18 (a) Funeral director C. Henry Dr & Son Inc

(b) Address 3615-17 Chestnut Ave.

19 (a) (b)

(Date received by registrar) Registrar

MAR 28 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944 at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1944 to March 27 1944, and that I last saw h ER alive on 3/27 1944.

Immediate cause of death Cardio-respiratory failure — Duration ?

Due to Chronic Glomerular nephritis & Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George W. Hunyadi Jr. M. D.

Address 332 E. University Pkwy. Date signed 3/27/44

G 15577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G 15577 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 N. Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lydia Arter

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1886

8. AGE: Years 58 | Months 1 | Days 5 | If less than one day: hr. min.

9. Birthplace: York Co. Pa. (Town, county and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Theodore Stephens
13. Birthplace: York Co. Pa.

MOTHER
14. Maiden Name: Nora Mayer
15. Birthplace: Cumberland Co. Pa.

16 (a) Informant: Eleanora Mae Arter
(b) Address: 1007 N. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28, 1944 (month) (day) (year)
(c) Cemetery or crematory: Mechanicsburg, Pa.
Location

18 (a) Funeral director: Mrs. George H. Holland
(b) Address: 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1944, at 8:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1944, to Mar 26 1944, and that I last saw h[illegible] alive on Mar 26 1944.

Immediate cause of death: Arteriosclerosis - senescence.
Due to
Due to
Other Conditions: Myocarditis

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. J. Bongiaco M. D.
Address: Provident Hospital Date signed 3/28/44

G 15578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G 15578

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 N. Arlington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary H. Hammond

3 (b) **If veteran, name war**

3 (c) **Social Security Account No.** None

4. **Sex** Female

5. **Color or race** Colored

6 (a) **Single, married, widowed, or divorced** Widow

6 (b) **Name of husband or wife** John

6 (c) **If alive, give age** years

7. **Birth date of deceased (mo., day, yr.)** July 2, 1885

8. **AGE:** Years 58 | Months 8 | Days 24 | If less than one day hr. min

9. **Birthplace** Maryland (Town, county, and state)

10. **Usual Occupation** Housewife

11. **Industry or business**

FATHER
12. **Name** Wm C. Bevans
13. **Birthplace** Maryland

MOTHER
14. **Maiden Name** Henrietta Coale
15. **Birthplace** Maryland

16 (a) **Informant** Wm J. Hammond
(b) **Address** 510 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) **Date thereof** March 29 1944 (month) (day) (year)
(c) **Cemetery or crematory** New Cathedral
Location Baltimore Md

18 (a) **Funeral director** Mrs. George W. Holland
(b) **Address** 1631 Druid Hill Ave.

19 (a) (Date received by local registrar) MAR 28 1944 (Registrar) Mustering for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Mar 26 19 44 at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1943 to Mar 26 19 44 and that I last saw h alive on Mar 25 19 44

Immediate cause of death Cardio Vascular Renal Disease — **Duration** 1 yr.

Due to Chronic Nephritis — 3 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. **Signature** Wm Graham Frey M. D.
Address 1728 Eutaw Pl. Date signed 3/28/44

G 15579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 G 15579

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 838 N. Carey St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 838 N. Carey St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William Alfred Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jane Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12 1884

8. AGE: Years 60 | Months -4 | Days -12 | If less than one day: hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name John Berry
13. Birthplace Howard Co. Md.

MOTHER 14. Maiden Name Susan Berry
15. Birthplace Howard Co. Md.

16 (a) Informant Jane Dorothy Berry
(b) Address 838 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Jas. George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) MAR 28 1944 (Date filed by registrar) (b) Fountain [illegible] Registrar

FORM VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 , at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944 to Mar. 24 1944, and that I last saw him alive on Mar. 23, 1944.

	Duration
Immediate cause of death Cerebral Haemorrhage	some years
Due to Arterio-Sclerosis	4 years
Due to Cardio-vascular disease	
Other Conditions Essential Hypertension	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. S. Victor Smith
Address 844 N. Carey st. Date signed 3/28/44 M. D.

G 15580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15580 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Atkinson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Atkinson Street (If rural give location)
(e) Citizen of foreign country? — no — (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Blanche Bryson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Daniel M. Bryson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 3, 1863

8. AGE: Years	Months	Days	If less than one day
80	10	23	24 — hr. — min.

9. Birthplace Harford Co., Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Robert A. Preston
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Francis
15. Birthplace Maryland

16 (a) Informant Mrs. Ruth Pugh
(b) Address 2727 Atkinson St, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Sater's Cemetery
Location Baltimore County, Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland.

19 (a) MAR 28 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1944 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 21 – 1944, to Mar 26 1944 and that I last saw h alive on Mar 26 – 1944.

Immediate cause of death
Cerebral hemorrhage
with left hemiplegia
Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
6 days
[illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at. M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. J. Kellan M. D.
Address [illegible] Monument St Date signed 3/27/44

G 15581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 15581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1377 Wheatcroft St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1377 Wheatcroft St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harold Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. 199-05-1046

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 4 15

8. AGE: Years 29 Months 28 Days If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name George Sale

13. Birthplace Va.

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Rena Sale

(b) Address 1309 Pressman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Cem.

Location Md

18 (a) Funeral director George G. Kelson

(b) Address 1303 Presstman St

19 (a) MAR 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 19 44 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 19 44. to Mar 24 19 44. and that I last saw h living alive on Mar 24 19 44.

Immediate cause of death Acute Nephritis — Duration Unknown

Due to Lobar Pneumonia — Duration 11 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 3/28/44

G 15584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15582 Registered No. 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) ~~Hospital or~~ institution: Home for the Aged of the M. E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 22nd 1858

8. AGE: Years	Months	Days	If less than one day
86	2	4	hr min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary E. Collins
15. Birthplace Balto. Md.

16 (a) Informant Miriam S. Coates
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3-27-44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by local reg.) Thursday (Signature of local registrar) Registrar

MAR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 26th 1944, at 12 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1944, to Mar 25 1944, and that I last saw h[er] alive on 3-25 1944.

Immediate cause of death: Myocardial Insufficiency — Duration: 5 days
Due to Arteriosclerosis — 15 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies M. D.
Address 800 W 33rd St Date signed 3-27-44

G 15583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G 15583 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Argyle ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary [redacted] Bailey.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife John S. Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Horace Bias
13. Birthplace Howard Co.

MOTHER
14. Maiden Name Sarah Boston
15. Birthplace Howard Co., Md

16 (a) Informant John Bailey
(b) Address 1716 N. Eagle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Hattie R. Williams
(b) Address 322 N. Schroeder Str

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944 at 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1943 to 3-23 1944.
and that I last saw h alive on 3-22 1944.

Immediate cause of death Cerebral Hemorrhage
Cardio-Vascular Renal Disease

Duration Not Stated

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Thomas M.D.
Address 30 S. Dearborn Ave Date signed 3-27 1944

G 15584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15584 Registered No. 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Ave
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Chestnut Hill Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Joesting, Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Rose Joesting
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 - 1865

8. AGE: Years	Months	Days	If less than one day
78	8	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Henry Joesting.
13. Birthplace Hannover Germany

MOTHER
14. Maiden Name Mary Myers
15. Birthplace Osnabruck Germany

16 (a) Informant Daughter - Miss Edith Joesting
(b) Address 518 Chestnut Hill Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mar. 29-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md.

18 (a) Funeral director Maurice Cook-Syfer
(b) Address 1660 W. North Ave.

19 (a) (Date received by Registrar) MAR 28 1944 (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 March 1944 at 8 02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Mar. 1944 to 27 Mar 1944 and that I last saw h/im alive on 27 Mar. 1944.

Immediate cause of death acute cardiorespo. failure — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill M. D.
Address Main Memorial Hosp Date signed 3-27-44

G 15585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 15585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1831 Penrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 Penrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Charles E. Strober

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
000	705-05-7836	Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 20, 1884

8. AGE: Years	Months	Days	If less than one day
59	7	6	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Cashier-Camden Freight office
11. Industry or business B. & O. R. R.

FATHER
12. Name Jacob E. Strober
13. Birthplace W. Va.

MOTHER
14. Maiden Name Emma E. Marshall
15. Birthplace W. Va.

16 (a) Informant Mrs. Emma E. Reber
(b) Address 1831 Penrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave, Balto. Md.

18 (a) Funeral director E. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Date received by Registrar) 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION 9.30

20. DATE OF DEATH Mar. 26, 1944 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1944, to March 26, 1944 and that I last saw him alive on March 24, 1944

Immediate cause of death	Duration
Coronary Thrombosis	Few days
Due to arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Knupp
Address 333 Edmondson Ave. Date signed M. D. 3/27/44

Huntington Ind.

G 15586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 15586 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1404 Grinders Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Grinders
(c) City or town 1404 Grinders Court (If outside city or town limits, write RURAL and give town)
(d) Street No. 1a (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter E. Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 242-05-3715

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Albert Hopkins
13. Birthplace N.C.

MOTHER
14. Maiden Name Katie ?
15. Birthplace

16 (a) Informant Anna Hopkins
(b) Address 1404 Grinders Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Raleigh, N. C.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAR 28 1944 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944, at 1:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Concussion of brain; subarachnoid hemorrhage & edema of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Unknown at M.
(b) Where did injury occur? Unknown
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury Probable fall.

23. Signature Robert L. Graham M.D. Medical Examiner
Date signed March 29 1944

VS 151

G 15587 ✓ G 15587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Harrison

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Sarah Shanahan Harrison 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1900

8. AGE: Years	Months	Days	If less than one day
43	3	26	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation News paper Salesman
11. Industry or business News Stand

FATHER
12. Name George A. Harrison
13. Birthplace Germany

MOTHER
14. Maiden Name Ida A. Mading
15. Birthplace Germany

16 (a) Informant Mrs. Ida A. Mangels (b) Address 1117 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 30/44 (month) (day) (year)
(c) Cemetery or crematory Morland Memorial Pk
Location East of Harford Rd on Taylor Ave

18 (a) Funeral director Elmer W. Corkran & Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 21 MAR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944, at 2:50 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed skull, left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 9/9 A

(a) Date of injury March 27 1944 2:15 M.
(b) Where did injury occur? 700 E. Lexington Preston St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Struck by auto

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed March 27 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15588

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 126

G 15588 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 N. Fayette Street
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4908 York Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie E. Otto.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John F. Otto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26 1881

8. AGE: Years	Months	Days	If less than one day
62	4	1	hr. min.

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Jutt
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine Linthicum
15. Birthplace Maryland

16 (a) Informant Mrs. Myrtle Benson
(b) Address 3537 Greenmount Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29-1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co. Md.
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) MAR 28 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1944, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1944 to 3-27 1944 and that I last saw her alive on 3-27 1944.

Immediate cause of death: Congestive Heart Failure — Duration 15 hrs.
Due to: Hypertension Cardio-Vas. Disease
Due to:
Other Conditions: Cholecystectomy - 3-22-44
(Include pregnancy within 3 months of death)
Date of operation 3-22-44
Major findings of operation: Chronic Cholecystitis & Cholelithiasis
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Uyei Jr. M. D.
Address Bon Secours Hosp. Date signed 3-27-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G 15589 ✓ G 15589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46a

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution: St. Joseph's - Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 N Linwood Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mr. Frank Lennon.
3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Blanche.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-15-90.

8. AGE: Years	Months	Days	If less than one day
54	2	6	hr ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name George H Lennon
13. Birthplace Salmon Va.

MOTHER
14. Maiden Name Minnie Lee Eaton
15. Birthplace Abingdon Va.

16 (a) Informant Mrs Blanche Lennon
(b) Address 1223 N Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location .....

18 (a) Funeral director John Ulrich
(b) Address 2008 Orleans St

19 (a) ..... (Date rec'd by registrar) (b) Huntington (Signature of registrar)

MAR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1944, at 12:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1944 to 3-24 1944, and that I last saw him alive on 3-24 1944:

Immediate cause of death	Duration
Peripheral Circulatory failure	
Due to Cancer of Esophagus & metastasis locally.	
Due to	
Other Conditions Edema Pneumonia Lt. Base - Chronic Tbc Peritonitis - Pleurisy	

(Include pregnancy within 3 months of death)

Date of operation 3-20-44
Major findings of operation: Esophageal Cancer
of autopsy: Some - Chronic Pleurisy - Pneumonia, Tbc Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Stanley B. Klyamowe, M. Dr.
Address St Josephs Hosp Date signed 3/24/1944

G 15590

G 15590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4528 Weitzel Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4528 Weitzel Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy HAMMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1944

8. AGE: Years	Months	Days	If less than one day
			4 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold C. Hammer
13. Birthplace Brooklyn N.Y.

MOTHER
14. Maiden Name Alberta F Bayne
15. Birthplace Roanoke Va.

16 (a) Informant Mr Harold C. Hammer
(b) Address 4528 Weitzel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Baltimore

18 (a) Funeral director Leonard Hyatt
(b) Address 5205 Harford Rd.

19 (a) Mar 28 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1944 19 .
and that I last saw him alive on March 25 1944.

Immediate cause of death Congenital atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M.D.
Address 4706 Harford Road Signed 3/26/44

VS 150

G 15591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15591 Registered No. 92E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd.
(c) Hospital or institution: Shriner Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EMMA DOROTHEA VORDEMBERGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1867

8. AGE: Years 76 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Koerting
13. Birthplace Md.

MOTHER
14. Maiden Name Christina Miller
15. Birthplace Md.

16 (a) Informant Mr. Louis M. Vordemberge
(b) Address 816 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Wm. J. Tickner & Sons Inc. Williams H.P. Funeral Director

(Date received by Local Registrar) MAR 28 1944
VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/ 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10 1944, to Mar. 27 1944, and that I last saw h[illegible] alive on Mar 26 1944.

Immediate cause of death: Myocardial insufficiency — Duration 2 days
Due to: senility
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Labotte Ewalt
Address 2945A Paul St Date signed 3/28/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 15592

15592 V 923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3429 Dupont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3429 Dupont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE A. GROENINGER

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillie R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1870

8. AGE: Years	Months	Days	If less than one day
73	6	29	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name George Groeninger
13. Birthplace Germany

MOTHER
14. Maiden Name Sallie Kriess
15. Birthplace Germany

16 (a) Informant Mrs. Lillie R. Groeninger
(b) Address 3429 Dupont Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 30 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25, 1944, at 7.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28- 1943, to Mar 25 1944 and that I last saw alive on Mar 25 1944

Immediate cause of death

Mitral Insufficiency

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration: ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm D Bubert M. D.

Address 1003 Park Heights Ave Date signed 3/27/44

C 15593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. C 16593

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Sterling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Sterling St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Nichols Stewart (Smith) (Delgado) (Barton)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Barton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10 1887

8. AGE: Years 57 Months 3 Days 14 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ike Nichols

13. Birthplace Nukuoro

MOTHER 14. Maiden Name Julia Stewart

15. Birthplace Baltimore Md.

16 (a) Informant Myrtle Leary (Sister)

(b) Address 1030 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location

18 (a) Funeral director Robert L. Young

(b) Address 804 N. Caroline St.

MAR 28 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to March 24 1944. and that I last saw h e alive on March 24 1944.

Immediate cause of death Chronic Nephritis — Duration 1 yr.

Due to Uremia — 3 days

Due to

Other Conditions Chronic Diabetes Mellitus — 1 yr.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph L. Young M.D.

Address 1424 E. Monument St Date signed 3/29/44

G 15594

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15594 Registered No. 1578

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Balt Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. South Balt Gen. Hosp. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Hahn (Dorothy M Hahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, '43

8. AGE: Years | Months: 3 mo 2 | Days: 28 | If less than one day: hr. min.

9. Birthplace South Balt General Hosp (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Hahn
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth A Pumphrey
15. Birthplace Md

16 (a) Informant Mrs Elizabeth A. Hahn
(b) Address Green Haven Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director William M Marcks
(b) Address 715 Light St

19 (a) (b)
Date received by registrar MAR 28 1944 Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1944, at 6 am P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1943, to March 25 1944 and that I last saw h[illegible] alive on March 25 1944.

Immediate cause of death: mal nutrition

Due to Cleft palate & bare-lip bilateral

Due to congenital deformity.

Other Conditions Miscellaneous

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr Geo Brooke West Jr M. D.
Address South Balt General Hosp. Date signed 3-25-44

Remarks: Huntington Williams, M.D.

G 15595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 15595 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Welcome Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hollis A. Day

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name	unknown
FATHER 13. Birthplace	unknown
MOTHER 14. Maiden Name	unknown
MOTHER 15. Birthplace	unknown

16 (a) Informant Victoria Brice
(b) Address 105 W Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/ (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A B & Md

18 (a) Funeral director Isaiah L Brownlow
(b) Address 108 W Montgomery Street

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1944, at 2.30 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Dexter F. Tubman M.D. Medical Examiner.
Date signed 3/22/44

Fill in all items carefully, with DARKENING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

451542

G 15596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15596
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [illegible] 15
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days Life

2 USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Bekana Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn Alley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 7-9-43

8. AGE: Years 9 | Months | Days 17 | If less than one day hr min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

MOTHER | FATHER
12. Name Edward Alley
13. Birthplace Va.
14. Maiden Name Ruth
15. Birthplace

16 (a) Informant Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd

18 (a) Funeral director Harry A. Witzke
(b) Address 410 Edmondson Ave Huntington Indiana

MAR 28 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1944 at 5 pm M

21. I certify that death occurred on the date above stated, that I attended deceased from Mar 24 1944 to Mar 26 1944 and that I last saw her alive on Mar 26 1944

Immediate cause of death. Duration
Cardiac failure immediate
Due to renal insufficiency 4 days
Due to
Other Conditions acidosis 5 day
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically

23. Signature Elizabeth Conrad M.D.
Address Johns Hopkins Hosp Date signed 3-26-44

G 15597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15597 — Registered No. 82a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Co
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Evangeline Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country 2680 Wilkens Ave

3 (a) FULL NAME George E. Gettier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Agnes nee Herring

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 4, 1882

8. AGE: Years 65 | Months 11 | Days 23 | If less than one day: hr. min

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Teamster

11. Industry or business

FATHER — 12. Name Geo. P. Gettier
13. Birthplace Md.

MOTHER — 14. Maiden Name Virginia Reed
15. Birthplace Md.

16 (a) Informant Mrs Elsie Ailsworth
(b) Address 2024 W. Pratt st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-42 (month) (day) (year)

(c) Cemetery or crematory Oakland
Location Balto md.

18 (a) Funeral director N. Guy N. Wilkes
(b) Address 4101 Edmondson Ave

19 (a) Filed Mar 28 1942 (Date rec'd by registrar) Registrar

Approved by Robert Lee Graham M.D. for H.L. Wollenweber M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3, 27, 42 19 . at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3, 27 19 42 to 3, 27 19 42, and that I last saw h (alive on 3, 27 19 42.

Immediate cause of death Cerebral Hemorrhage

Due to Severe Essential Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature
Address Date signed 3-30-42

G 15598

G 15598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 15598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 E. Eager St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HATTIE A DIETZ

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife John Dietz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1896

8. AGE: Years 47 | Months 9 | Days 11 | If less than one day hr. min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oscar Unger
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Rothling
15. Birthplace Germany

16 (a) Informant Miss Margie Dietz
(b) Address 2201 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31, 44 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem Pk
Location Balto Md

18 (a) Funeral director Philip Henry Stone
(b) Address 2424 Eastern Ave.

MAR 28 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 1944, at 8:40 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D.
Medical Examiner
Date signed 3-25-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15599

G 15599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82 R

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 Jefferson St (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Walter Yent (YENT)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Aug. 9, 1881

8. AGE: Years 62 | Months 7 | Days 17 | If less than one day: hr. ..... min. .....

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business .....

FATHER
12. Name Charles Yent
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Elizabeth Mundelly
15. Birthplace Baltimore, Md

16 (a) Informant George Yent
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30/44 (month) (day) (year)

(c) Cemetery or crematory Bal Lawn
Location Bal MD

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Eutaw St

19 (a) ..... (b) ..... (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1944, at 11 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage
Brain

Due to Thrombosis of internal carotid artery, left

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 27 1944

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G 15600

G 15600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 5-E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Pasadena, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Wh	Widower

6 (b) Name of husband or wife Marian Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1

8. AGE: Years	Months	Days	If less than one day
71	9	13	hr min

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Gen'l farm

11. Industry or business

FATHER 12. Name Dan Moore

13. Birthplace Pa.

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Mrs. Willard

(b) Address 1122 Sergeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar (month) (day) (year)

(c) Cemetery or crematory Larkwood

Location Baltimore

18 (a) Funeral director Rita Wedgefield

(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by registrar) Registrar

MAR 28 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1944, at 2:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 7 1944, to Mar 27 1944, and that I last saw him alive on 3/26 1944.

Immediate cause of death Resp failure — Duration —

Due to Carcinomatosis (primary site not yet known)

Due to

Other Conditions Multiple infarcts of lungs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinomatosis

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Leonard Abrams M. D.

Address Sinai Hosp Date signed 3/27/44

G 15601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15601 Registered No. 121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 814 Gorsuch Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

a. State Md b. County

c. City or town Baltimore (If outside city or town limits, write RURAL and give town)

d. Street No. 814 Gorsuch Ave (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Zalinda L Link

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Godfrey A. Link

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 22, 1860

8. AGE: Years 83 Months 11 Days 23 If less than one day hr. min

9. Birthplace Va (Town, county, and state)

10. Usual Occupation no

11. Industry or business

FATHER 12. Name Jos B Frasell

13. Birthplace Md

MOTHER 14. Maiden Name Lydia A Gordon

15. Birthplace Balto

16 (a) Informant Lydia Link

(b) Address 814 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 917 Greenmount Ave

19 (a) Filed by registrar Huntington Williams, M.D. Registrar

MAR 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1944, at 10:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from March 17 1944 to March 25 1944, and that I last saw h alive on March 24 1944.

Immediate cause of death Coronary Cardio-Vascular Renal disease — Duration 10 years

Due to Generalized Arteriosclerosis. — 10 years.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ira Timmins

Address Medical Arts Bldg Date signed 3/27/44

G 15602

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15602 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 Bolton street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore----
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 Bolton street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

13-V

3 (a) FULL NAME EDWIN A. HEDIAN

3 (b) If veteran, name war -------

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Widower

6 (b) Name of husband or wife Emma M. Hedian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1861

8. AGE: Years	Months	Days	If less than one day
82	4	8	hr min

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Patrick J. Hedian
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Angela Maffei
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Helene Hedian
(b) Address 2112 Bolton street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 26 1944 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/26 1944 to 3/26 1944, and that I last saw h[illegible] alive on 3/26 1944.

Immediate cause of death: Coronary Occlusion — Duration: 1 hour

Due to: Chronic Arteriosclerosis — Duration: ?

Due to: Enlarged Prostate — Duration: 5 yrs

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
I underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —
23. Signature [illegible]
Address [illegible] Date signed 3/27/44 (M.D.)

G 15603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15603 Registered No.

121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 Homestead Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) about 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Homestead St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Bridgit Theresa Donohue

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John J. Donohue

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1865

8. AGE: Years 79 | Months 1 | Days 13 | If less than one day ###### min

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name ? O'Leary
13. Birthplace Ireland

MOTHER
14. Maiden Name (Unknown)
15. Birthplace Ireland

16 (a) Informant Mrs. Milton John (Daughter)
(b) Address 1600 Homestead Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25th 1944, at 11:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15-1931 to 3-25-1944, and that I last saw her alive on 3-25-1944

Immediate cause of death: Cardio-renal disease — Duration: Unknown

Due to: Arteriosclerosis — Duration: Unknown

Due to:

Other Conditions: Pernicious anemia — Duration: 6 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically

23. Signature Geo B. Hyland M. D.

Address 2402 Harford Ln Date signed 3-27-44

G 15604

AB-86927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15604 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The street age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank William Siebebeichel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20-1868

8. AGE: Years 75 | Months 4 | Days 7 | If less than one day: hr min

9. Birthplace Austria (Vienna)
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Frank Wilhelm Siebebeichel
13. Birthplace Vienna, Austria

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 29/44 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Hooners Lane

18 (a) Funeral director John G. Miller
(b) Address 2334 Jefferson St.

19 (a) 3-28-1944 (Date filed by registrar) Registrar
Huntington Pittsworth

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1944, at 8 30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3/13 1944, to 3-27 1944, and that I last saw him alive on 3 27 19 44

Immediate cause of death
Bronchopneumonia — Duration: 7 days
Due to Hypostasis
Due to Injury Lt Leg — Duration: 6 wks ?
Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 3/24/44
Major findings of operation: Gangrene Lt Leg
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald B Webb M D
Address Balto City Hosp Date signed 3/27/44

G 15605 Doniecki

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 15605 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp 4 W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Govanstown Rural (If outside city or town limits, write RURAL, and give town)
(d) Street No. 25 Clyde Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Doniecki

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-2014

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21 1910

8. AGE: Years	Months	Days	If less than one day
34	2	6	hr. min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Copper Works

FATHER
12. Name Bernard J. Doniecki
13. Birthplace Poland

MOTHER
14. Maiden Name Eva Andryziak
15. Birthplace Baltimore Md.

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore Co, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Ann st.

19 (a) MAR 28 1944 (Date received by registrar) (b) Huntingtown Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944 at 4 45 PM

21. I certify that death occurred on the date above stated: that I attended deceased from Mar 25 19 44 to March 19 44 and that I last saw h alive on March 27 19 44

Immediate cause of death Acute Sec Resp. Failure
Due to Pneumonia
Due to Hypertensive Cardio Vascular Nephritis

Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Leverock MD
Address Mercy Date signed 3-27-44

VS 150

G 15606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G 15606 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (~~yrs. mos. or~~ days) 27 27
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Inglewood Ave #14 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW WILLIAM PROCTOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	214-01-2947

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bertha Frank Proctor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1880

8. AGE: Years	Months	Days	If less than one day
63 34	7	28 27	hr. min.

9. Birthplace Scotland, Edinburgh (Town, county, and state)
10. Usual Occupation Book binder, foreman
11. Industry or business retired 3 yrs.

FATHER
12. Name ? Proctor
13. Birthplace Scotland

MOTHER
14. Maiden Name ? Mann
15. Birthplace Scotland

16 (a) Informant James O. Proctor
(b) Address 2807 Inglewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 (a) Filed by Registrar (b) Remarks

MAR 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1944, at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1944 to 3-26 1944, and that I last saw him alive on 3-26 1944.

Immediate cause of death: Acute Cardiac Dilatation — Duration

Due to: Hypertension C V Disease

Due to:

Other Conditions: Acute Cystitis

(Include pregnancy within 3 months of death)

Date of operation 3-16-44

Major findings of operation: Benign prostatic hypertrophy

of autopsy: Above.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D Young Jr. M. D.
Address Med. Gen. Hosp. Date signed 3-26-44

15607 JL - 86942

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15607
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Market Place.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Service

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1879

8. AGE: Years	Months	Days	If less than one day
64	4	26	hr min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Odd jobs
11. Industry or business

FATHER
12. Name John L. Service
13. Birthplace N. Y.

MOTHER
14. Maiden Name Mary A. Cane
15. Birthplace Conn.

16 (a) Informant B. C. H. Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 25 1944
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) MAR 28 1944 (b) Hunting for Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22- 1944 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14- 1944, to 3-22, 1944, and that I last saw h/m alive on 3-22 1944.

Immediate cause of death	Duration
Pneumonia, Etc.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No (Post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Baltrica M. D.
Address 4940 Eastern Ave Date signed 3-22-44

0828

G 15608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G 15608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1548 Pennsylvania Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Cornish

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Single Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Cornish
13. Birthplace Unknown

MOTHER
14. Maiden Name Susan Summerville
15. Birthplace Unknown

16 (a) Informant Ernest Jackson
(b) Address 502 N. Parrish St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 28 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 28 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1944, at 1.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944, to March 15 1944, and that I last saw h/m alive on March 15 1944.

Immediate cause of death	Duration
Uremia	5 days
Due to Urinary obstruction	5 days
Due to Prostatic Hypertrophy	unknown

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles A Kemper M. D.
Address University Hosp Date signed 3/15

VS 150

0827

G 15609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15609 Registered No.

160C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 dy
(e) Length of stay in Baltimore (yrs., mos., or days) 1 dy

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 709 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Rice

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife None
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 1 | If less than one day ... hr. ... min

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wayne Rice
13. Birthplace Ky.

MOTHER
14. Maiden Name Sarah Ramey
15. Birthplace Ky.

16 (a) Informant Sarah Rice
(b) Address 709 W. Fayette St

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 28 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1944 at 2.25 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1944 to 3-23 1944, and that I last saw her alive on 3-23 1944

Immediate cause of death Respiratory Failure — Duration

Due to Aspiration of amniotic fluid.

Due to Premature separation of placenta

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. M. Jones Jr. M. D.
Address Date signed 3-24

0829

G 15610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15610 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Pride

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1912

8. AGE: Years	Months	Days	If less than one day
31	5	14	hr. min.

9. Birthplace Henrico Co., Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Pigram
13. Birthplace Va

MOTHER
14. Maiden Name Louise Pride
15. Birthplace Va

16 (a) Informant Matilda Palmer
(b) Address 413 N. Eden st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/44 (month) (day) (year)
(c) Cemetery or crematory
Location Stoney Creek, Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Edmondson Ave

19 (a) (Date received by registrar) (b) Registrar

MAY 25 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1944, at 3 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1944, to March 26 1944, and that I last saw h (illegible) alive on March 26 1944

Immediate cause of death: Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Banfield, M. D.
Address Provident Hospital Date signed 5/28/44

G 15611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G 15611 No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Edward 1 Greene St.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 8

(e) Length of stay in Baltimore (yrs., mos., or days) ? ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 420 N. Fremont Ave. (If rural, give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country —

3 (a) FULL NAME Maggie Martin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Colored	Widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	10	24		

9. Birthplace Accomac, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Thomas Brickers

13. Birthplace Va.

MOTHER 14. Maiden Name Jane Sample

15. Birthplace Va.

16 (a) Informant Margaret Frottie

(b) Address 420 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1420 Pennsylvania Ave

19 (a) MAR 28 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25/44 1944, at 10 o'clock M

21. I certify that death occurred on the date above stated, that I attended deceased from 8:35 A.M. 3/20/44 to 10 A.M. 3/25/44 1944, and that I last saw her alive on 3/25/44 1944.

Immediate cause of death Respiratory and Cardiac failure

Due to Cancer unknown. Patient was being given Ether Anesthesia for Radium Implantation for Cervix

Due to

Other Conditions Carcinoma of Cervix.

(Include pregnancy within 3 months of death)

Date of operation No operation

Major findings of operation:

of autopsy: Not done

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Jones M. D.

Address Univ. Hosp. Date signed 3/25/44

G 15612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 15612
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther Salit

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1892

8. AGE: Years	Months	Days	If less than one day
51	9	26	hr min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Nathan Friedenberg
13. Birthplace Poland

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Poland

16 (a) Informant Samuel Salit
(b) Address 2004 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date received by registrar) (b) (Registrar)

VS 150 MAR 28 1944 Hunter's Lane Pittsburgh, Pa.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944, at 905 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1944, to March 28 1944, and that I last saw h[illegible] alive on March 28 1944.

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M.D. M. D.
Address Sinai Hosp. Date signed 3/26/44

G 15613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

G 15613 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 ParkHeights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Wolcott Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business Tailor

FATHER
12. Name Rubin Ruth
13. Birthplace Russia

MOTHER
14. Maiden Name Dora ?
15. Birthplace Russia

16 (a) Informant Mrs Anna Ruth
(b) Address 3001 Wolcott Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North ave

19 (a) (Date received by Registrar) (b) Registrar
MAR 28 1944
VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1944, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19.. to March 28 1944, and that I last saw him alive on March 24 1944.

Immediate cause of death: Carcinoma Lung (left) — Duration: 7 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 1943

Major findings of operation: Carcinoma Lung.

of autopsy: none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton E. Lowman M. D.
Address 5013 Park Heights Ave Date signed 3/28/44

G 15614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15614 Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3945 Boarman Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

15 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3945 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wolf Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Junk Business

FATHER
12. Name Emanuel Goldberg
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Mrs Annie Goldberg
(b) Address 3945 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) MAR 28 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1944, at P.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1942 to 3/25 1944.
and that I last saw h[illegible] alive on 3/25 1944.

Immediate cause of death Chronic Nephritis
Hypertension
Uremia
Due to Hypertension Arteriosclerosis
Due to Frost bite
Hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Krauchey M. D.
Address 1224 W Lee Date signed 3/28/44

G 15615

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15615 X 137a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 E. 6th St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Edward Weedon

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-16-0626

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Ada V. Brooks
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3/17/1877

8. AGE: Years	Months	Days	If less than one day
67	0	10	hr. ..... min.

9. Birthplace Md (City, county, and state)
10. Usual Occupation Laborer
11. Industry or Business

FATHER
12. Name Stephen Weedon
13. Birthplace Balt. Co. Md

MOTHER
14. Maiden Name Nancy Tobey
15. Birthplace Balt. Md.

16 (a) Informant Mrs. Edward Weedon
(b) Address 7 E. 6th St Frederick, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/44 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cem.
Location Baltimore, Md.

18 (a) Funeral director M. A. Eichelberger
(b) Address Frederick, Md.

19 (a) ..... (Local registrar) (b) Huntington Williams, M.D.

MAR 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944 at 6.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 22 1944 to Mar 27 1944 and that I last saw h[illegible]live on Mar 27 1944

Immediate cause of death Coronary occlusion — Duration .....

Due to Benign Prostatic Hypertrophy .....

Due to Generalized Arteriosclerosis .....
Parkinsons Disease .....

Due to Diverticula of Urinary bladder .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation 3/27/44

Major findings of operation: [illegible]

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Russell B. Roth M.D.
Address Johns Hopkins Hosp. Date signed 3/27/44

(over)

G 15616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 2/27/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 2/27/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 137 E. Green Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOS. CARBERY BOYLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
World's War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1893

8. AGE: Years	Months	Days	If less than one day
50	7	6	hr. min

9. Birthplace Westminster, Maryland (Town, county, and state)
10. Usual Occupation Foreman, State Roads Comm.
11. Industry or business -

FATHER
12. Name Jos. B. Boyle
13. Birthplace Westminster, Md.

MOTHER
14. Maiden Name Mary C. MacSherry
15. Birthplace Georgetown, D. C.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 30-1944 (months) (day) (year)
(c) Cemetery or crematory St. Johns Catholic
Location Westminster, Md.

18 (a) Funeral director H Bankard Son
(b) Address W. estminster Md.

19 (a) MAR 29 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Mar. 28, 1944 at 9:52 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27, 1944 to Mar. 28, 1944 and that I last saw him alive on Mar. 28, 1944

Immediate cause of death Malignant Hypertension — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify) (type of place)
(e) Means of injury

23. Signature H. Caruso,
Address Baltimore, Md. Date signed 3/28/44

Va-14342

G 15617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G 15617 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 710 Newington Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 710 Newington Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bertha Wolfsheimer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 1884

8. AGE: Years 59 | Months 7 | Days 24 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Nathan Wolfsheimer

13. Birthplace Germany

14. Maiden Name Babette Stoffhare

15. Birthplace Balto Md

16 (a) Informant Mr. Maurice Schaffer

(b) Address 710 Newington Ave

17 (a) Burial (Burial, cremation, removal) (b) Date of [illegible] (Month) (day) (year) 3-31-44

(c) Cemetery or crematory Shel Shalom Cemetery

Location Druid Hill Ave

18 (a) Funeral director J. Gregory Sons

(b) Address 2103 Eastern Ave

MAR 28 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-28 1944 at 8:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to 3/28 1944.

and that I last saw him alive on 3/28 1944.

Immediate cause of death: Cardiac Decompensation — Duration: 2 mos.

Due to: Cardiac Hypertrophy

Hypertension

Due to:

Other Conditions: General arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or Town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Theodore Cooper M.D.

Address 2107 Park Ave Date signed 3/28/44

Theodore Cooper

15618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15618 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 63 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward Lurmon Rich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mary A. Rich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12th 1870

8. AGE: Years	Months	Days	If less than one day hr.	min.
73	3	14		

9. Birthplace Reisterstown Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Mosbach Bros.

FATHER
12. Name Edward A. Rich
13. Birthplace Reisterstown

MOTHER
14. Maiden Name Virginia Miller
15. Birthplace Balto. Md.

16 (a) Informant Edw L. Rich Jr
(b) Address Catonsville Md

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/29/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1944, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23 1943 to Mar. 26th 1944 and that I last saw he~~r~~ alive on March 15 1944.

Immediate cause of death
1) Arterio-sclerotic Heart Disease — Duration 2 yrs.
Due to
Due to
Other Conditions - Chronic Bronchitis — 2 yrs.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers
Address 4108 Liberty Hts Date signed 3/27/44 M. D.

G 15619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 15619 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2922 Ridgewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15/13
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Ridgewood Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Elkin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 53 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Solomon Slatkin
13. Birthplace Russia

MOTHER
14. Maiden Name Gussie
15. Birthplace Russia

16 (a) Informant Joseph Elkin
(b) Address 2922 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-44 (month) (day) (year)
(c) Cemetery or crematory Russdale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1429 E. Baltimore St

MAR 29 1944 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION 30

20. DATE OF DEATH 3-28 1944 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943, to March 28 1944, and that I last saw h er alive on 3/28 1944.

Immediate cause of death: Diabetes Mellitus (3) — Duration: 6 mos
Due to: Arterio Sclerosis CV Disease — 6 mos
Due to: Angina Pectoris — 4 mos
Other Conditions: Cardiac Failure — 1 Hour
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex A Wenstrom M. D.
Address 4603 Park Heights Ave Balto #15, Md Date signed 3-29-44

G 15620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G 15620 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital (DOA)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 873 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race C.

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 66 | Months | Days | If less than one day hr. min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Miss Fisher

(b) Address 873 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) MAR 29 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1944 at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Huntington Williams M.D. Medical Examiner

Date signed 3-29-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

G 15624 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Bolton St. City 14
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Sandridge Pinkerton

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-3428

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Mrs. Caroline Houghton Pinkerton (Dec.) 6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) [illegible] 1884

8. AGE: Years	Months	Days	If less than one day
59	4	12th	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Factory Representative
11. Industry or business

FATHER
12. Name Mr. Allen G. Pinkerton (D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Isabelle Coulson (D)
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29/44
(c) Cemetery or crematory Druid Ridge
Location Baltimore Maryland

18 (a) Funeral director John Mitchell Howe
(b) Address 1908 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1944, to 3-28 1944, and that I last saw him alive on 3-28 1944.

Immediate cause of death Cardio-Respiratory failure. — Duration ?

Due to Uremia

Due to Hypertensive Cardio-Vascular Renal disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Stephen J. Van Dill M. D.
Address Union Memorial Hosp Date signed 3-29-44

G 15622

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

162H

Registered No. G 15622

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Pentridge Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Pentridge Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth N. Gisriel

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Wm. A. Gisriel

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) July 25, 1909

8. AGE: Years 34 | Months 8 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation home duties

11. Industry or business

FATHER
12. Name Robert S. Nelson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Edith M. Myers
15. Birthplace Balto. Md.

16 (a) Informant Wm A. Gisriel
(b) Address 1519 Pentridge Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof March 31/44 (month) (day) (year)

(c) Cemetery or crematory Green Mount
Location Northeast Ave. & 11 ave

18 (a) Funeral director John O. Mitchell
(b) Address 1200 Eutaw Place

19 (a) APR 20 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-28- 1944, at 5 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Asphyxiation

Due to Lacerating Gas

Other Conditions Unconscious

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-28-44 at 4 A M.
(b) Where did injury occur? 1519 Pentridge Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
Means of injury Illuminating Gas range

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-29-44

G 15623

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 182a

G 15623 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 Linden Grove Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Linden Grove Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES NORVILLE LEIMBACH

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1943

8. AGE: Years	Months	Days	If less than one day
	8	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER 12. Name Charles Selfair Leimbach
13. Birthplace Baltimore

MOTHER 14. Maiden Name Virginia Boyd Norton
15. Birthplace Balto. Md.

16 (a) Informant Charles F. Leimbach
(b) Address 4009 Ridgefield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill
Location Lorraine Cemetery

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 9 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strangulation by bed clothes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-26-44 at 9 A.M.
(b) Where did injury occur? Home address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
Means of injury bed clothes

23. Signature H. L. Wallenmeyer M.D. Asst. Medical Examiner.
Date signed 3-28-44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

✓ G 15624 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3312 N. Northave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3312 N. North Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lillian Berry Reese

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1861

8. AGE: Years 82 | Months 9 | Days 4 | If less than one day hr min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation saleswoman retired

11. Industry or business

MOTHER / FATHER

12. Name John E. Reese

13. Birthplace Balto. Md.

14. Maiden Name Alice V. Gibbs

15. Birthplace Va

16 (a) Informant Annie L. Reese

(b) Address 3312 N. Northave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 30/44 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location North Greenmt. Ave.

18 (a) Funeral director John A. Mitchell Sons

(b) Address 1900 Eutaw Place

19 (a) MAR 29 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 28 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to Mar. 28 1944

and that I last saw h[illegible] alive on Mar. 27 1944

Immediate cause of death Pulmonary edema

Due to Myocardial failure

Due to Arteriosclerosis & hypertension.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
1 mo.
years.
year
"

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robt B. Wright M. D.

Address Med. Arts Bldg. Date signed 3/29/44

VS 150

G 15625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15625 Registered No.

12 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 O'Donnell St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 O'Donnell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy A. Slowik

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 15 1937

8. AGE: Years 6 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation School

11. Industry or business

MOTHER / FATHER

12. Name John Slowik

13. Birthplace Balto.

14. Maiden Name Julia Siewierski

15. Birthplace Poland

16 (a) Informant Mother

(b) Address 3010 O'Donnell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-44 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Dundalk Blvd

18 (a) Funeral director Stephan J. Fialkowski Inc.

(b) Address 1000 S. Kenwood Ave

19 (a) MAR 29 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944 at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1944 to March 27 1944 and that I last saw h alive on March 27 1944.

Immediate cause of death
Chronic Glomerular Nephritis
Myocardial Insufficiency

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gustav Slawinski M. D.

Address 2579 Eastern Ave. Date signed

VS 150

G 15626

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51B

G 15626 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution Maryland Geriatric Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cathedral & Madison (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Wilbur Newchester Myers

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife Single.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-21-1856

8. AGE: Years 87 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation retired.

11. Industry or business —

FATHER
12. Name Phillip Myers
13. Birthplace Penna. —

MOTHER
14. Maiden Name Elizabeth Thomas
15. Birthplace Penna

16 (a) Informant Ross Myers - (cousin)
(b) Address 900 W. Monument Pky.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-44 (month) (day) (year)
(c) Cemetery or crematory New Cedar Hill
Location New Cedar Hill P.O.

18 (a) Funeral director Stubbs & Monroe
(b) Address 1811 N. Monroe St.

MAR 29 1944 (Date rec'd by registrar)
(b) H. Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1944 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18/44 19— to 3/27 1944, and that I last saw him alive on 3/22 1944.

Immediate cause of death Cardiac Failure — Duration —
Due to P.O. to transurethral prostatic resection
Due to Ca of Prostate
Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 3/24/44
Major findings of operation: Ca of Prostate
of autopsy: ....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature H. H. Traynor M. D.
Address Wm. Keil Hosp. Date signed 3/27/44

VS 180

G 15627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G 15627 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 Ken Oak Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Ken Oak Road. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME SARAH M. WIESENFELD.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife David Wiesenfeld.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1852

8. AGE: Years	Months	Days	If less than one day
91	9	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isaac Metzger,
13. Birthplace Germany.

MOTHER
14. Maiden Name Fannie Hecht,
15. Birthplace Germany.

16 (a) Informant Mrs. S. Z. Rothschild,
(b) Address 2215 Ken Oak Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place.

19 (a) [illegible] Williams, M.D. (Date rec'd by Registrar) Registrar

MAR 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 27 1944, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25 1944 to Mar 27 1944 and that I last saw h[illegible] alive on Mar 26 1944.

Immediate cause of death	Duration
Pulmonary embolism:	
Pulmonary infarct	2 days
Due to Arteriosclerotic heart	
disease (mural thrombus)	3 yrs. 4 mos.
Due to Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis P. Hamburger M.D.
Address 1207 Eutaw Place. Date signed 3/29/44

G 15628

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 15628
CERTIFICATE OF DEATH 45a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 E. Clement Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Walecki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Andrew J. Walecki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1903

8. AGE: Years 40 | Months 7 | Days 27 2/6 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Eliza Pines
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary A. Martin
15. Birthplace North Carolina

16 (a) Informant Mr. Andrew J. Walecki
(b) Address 136 E. Clement Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director William M. Marecek
(b) Address 715 Light St

19 (a) (Date received by registrar) MAR 29 1944 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19 44 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an ..... Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Liver.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.
Date signed March 28, 1944

G 15629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G 15629

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Spring Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther Phair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mayer David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-6-9

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Husband

(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3-29-44 (month) (day) (year)

(c) Cemetery or crematory Southern Cem

Location Southern Ave

18 (a) Funeral director Jack Levys Inc

(b) Address 1439 E. Balto St.

19 (a) MAR 29 1944 (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1944, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Henry L. Wollenweber, M.D. Medical Examiner.

Date signed March 28, 1944.

Henry L. Wollenweber, by Howard J. Andersen, M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 470

Registered No. S-15630

S-15630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2426 Frederick Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 Frederick Avenue (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Priscilla Florence Reinhardt

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Albert J. Reinhardt
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 5, 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	8	23		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Joseph Schafer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary L. Mutz
15. Birthplace Balto. Md.

16 (a) Informant Robert J. Reinhardt
(b) Address 2426 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31 - 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director George Schenk
(b) Address 2101 Frederick Avenue

19 MAR 29 1944 (Registered by local registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 43 to 3,28, 1944 and that I last saw her alive on 3-27 1944.

Immediate cause of death Acute Dilitation of Heart — Duration 1 day

Due to Pneumonia of Lungs + Pleura — Duration 1 week

Due to

Other Conditions Blood Effusion — Duration 1 year

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marlin M. Shook M. D.
Address 2962 Fulton Ave Date signed 3-28-44

G 15631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 D G 15631 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wilson Park, Md
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5010 Beauregard Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Doda Morris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Hattie Woodridge M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1881

8. AGE: Years 63 | Months - | Days 2 | If less than one day hr. min.

9. Birthplace San Antonia Texas (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Hattie Woodridge Morris
(b) Address 5010 Beauregard ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katey R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944, at 12:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Hypertensive Cardio Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 27, 1944

VS 151

Please write plainly. Typewriting is preferable. Abbreviations are permissible. Please write the causes of death clearly and legibly.

G 15632

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46R

✓ G 15632 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2569 Pine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2569 Pine St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIE JOHNSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	married

6 (b) Name of husband or wife Richard Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Ellicott City Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Johnson
13. Birthplace Ellicott City, Md.

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace

16 (a) Informant Richard Johnson
(b) Address 256 N. Pine Street

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mrs. Winans

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25, 1944, at 10 P M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of stomach

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Attending and Medical Examiner.
Date signed 3-25-44

15633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G 15633

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 239 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Wilton Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 80 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace: Berlin, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: John Mc Horney
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Wilton Jackson
(b) Address: 239 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location: Mt. Winans

18 (a) Funeral director: Mrs. Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1944, at 4:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebro vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert L. Graham M.D. Medical Examiner.
Date signed: March 27, 1944

VS 151

G 15634

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 15634 Registered No. 8/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 W. Franklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Lacey Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Fisher
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Sarah Hing
15. Birthplace Eastern Shore, Md.

16 (a) Informant Lacey Lewis
(b) Address 704 W. Franklin st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) MAR 29 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944, at 9. A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent Meningitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 27, 1944

VS 151

15635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G 15635 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert & Saratoga Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore Patapsco Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bishop Avenue, Box 507
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Sheeters

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph Sheeters
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) May 9, 1897

8. AGE: Years 46 | Months 10 | Days 16 | If less than one day hr min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sandy Holmes
13. Birthplace S. C.

MOTHER
14. Maiden Name Mary Parsons
15. Birthplace S. C.

16 (a) Informant Joseph Sheeters, husband
(b) Address Bishop Ave., Box 507, Balto. Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-31-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Miss Katie R. Williams
(b) Address 322 N. Schroeder St

19 MAR 29 1944 (b) Registrar
(Date filed) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1944, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1944, to 3-26 1944, and that I last saw h[er] alive on 3-25 1944.

Immediate cause of death: Cardio-respiratory failure — Duration: about 48 hrs.

Due to: Pneumococcal meningitis

Due to:

Other Conditions: Carcinoma of ovary with metastasis to thorax & abdomen

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Ozazewski M. D.
Address Mercy Hosp. Date signed 3-26-44

G 15636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30E

G 15636
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 813 Pierce Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Palmer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Ma

6 (b) Name of husband or wife Minnie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15-

8. AGE: Years	Months	Days	If less than one day: hr.	min
70	-	11		

9. Birthplace Halifax Co. Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Palmer
13. Birthplace Va.

MOTHER
14. Maiden Name Priscilla
15. Birthplace Va

16 (a) Informant Mrs. Minnie Palmer
(b) Address 813 Pierce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 MAR 29 1944 (b) (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1944 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1944 to 3/26 1944, and that I last saw h[illegible] alive on 3/26 1944

Immediate cause of death	Duration
Cerebro-vascular accident	1 month
Due to Luetic cardio-vascular disease	unknown
Due to	
Other Conditions Hemiplegia Diabetes Mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature C. A. Kemper M. D.
Address University Hosp. Date signed 3/26

15637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

G 15637
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 583 Oxford St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 583 Oxford St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elma Dixon
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widow

6 (b) Name of husband or wife Daniel Dixon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 14. 1880

8. AGE: Years	Months	Days	If less than one day hr.	min.
63	11	13		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James W. Oliver
13. Birthplace Howard Co Md.

MOTHER
14. Maiden Name Rebecca Jacobs
15. Birthplace Ann Arundel Co Md

16 (a) Informant Herman Oliver
(b) Address 1611 W Mulberry St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/30/1944. (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Westport Md.

18 (a) Funeral director Mc Katie R Williams
(b) Address 322 N Schroeder St

19 (a) 3/29/44 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944. at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1944. to March 27 1944., and that I last saw h alive on March 27 1944.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	3 days
Due to (b) Cardiac Vascular Renal disease	not given
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles F Wardlaw M.D.
Address 921 Hanlon St Date signed 3/29/44

VS 250

G 15638

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15638 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2011 E. North Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANTON BERGER SIMONSEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ann C. Simonsen
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 3, 1890

8. AGE: Years	Months	Days	If less than one day
53 54	8	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Line Supt.
11. Industry or business Baltimore Transit

FATHER
12. Name Anton E. Simonsen
13. Birthplace Bergan, Norway

MOTHER
14. Maiden Name Carolina Ass
15. Birthplace Bergan, Norway

16 (a) Informant Mrs. Ann C. Simonsen
(b) Address 2011 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Baltimore County, Md.

16 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 29 1944 (b) Signature of Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/ 1944, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24/ 1943, to 3/25/ 1944, and that I last saw h[illegible] alive on 3/25 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 8-24-43 years

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weiss M. D.
Address 1927 E. North Ave. Date signed 3/28/44

VE 150

G 15639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution:
Franklin Square Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N. Arlington Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? No years

3 (a) FULL NAME Robert H. Jones, alias Robert H. Brown.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 218-10-9270

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jessie

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 12/2 5/1896

8. AGE: Years 47 | Months 3 | Days - | If less than one day: hr. min.

9. Birthplace Chestertown, Md.
(Town, county, and state)

10. Usual Occupation Porter
11. Industry or business Burkhart Mfg. Co.

FATHER
12. Name Thomas Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Julia ?
15. Birthplace Md.

16 (a) Informant Jessie Jones (Wife)
(b) Address 211 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1944 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25-44 19 , at 2.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/44 19 , to 3-25-44 19 , and that I last saw him alive on 3-25-44 19 .

Immediate cause of death

Acute Myocardial Failure — Duration: 2 hours
Due to Chronic Interstitial Heart Disease — Duration: 5 months
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 1) Healed heart & old scars 2) Pulmonary Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Franklin Square Hosp. Date signed 3-25-44

Instructions: Fill in all spaces applicable. If unknown, state so. Physicians, please write the causes of death clearly and legibly.

G 15640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 15640

Registered No.

Physicians: please write the causes of death clearly and legibly. Information as to correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument & Rutland Ave.

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2914 Elgin Ave. - 16 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Barbara Myra Shapiro.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-24-44

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER

12. Name Sydney Shapiro

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Naomi Hoffman

15. Birthplace Baltimore, Md.

16 (a) Informant Naomi Shapiro

(b) Address 2914 Elgin Ave.

17 (a) [redacted] burial (Burial, cremation, or removal) (b) Date thereof 3-29-44 (month) (day) (year)

(c) Cemetery or crematory Pikesville

Location

18 (a) Funeral director Jos. Levin Inc

(b) Address 1139 E. Baltimore St

19 (a) 3-29-1944 (Date rec'd by Registrar) (b) Huntington Hill Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1944, to 3/28 1944, and that I last saw h e alive on 3/28 1944.

Immediate cause of death Prematurity

Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Prematurity

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence , at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wilfred C. Konigsberg M. D.

Address 2240 Eutaw Place Date signed 3/29/44

G 15641

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 15641 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1840 W Baltimore St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County, —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1840 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME Agnes R. Lowd

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 3rd 1885

8. AGE: Years 58 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation house work
11. Industry or business at home

FATHER
12. Name John F. Lowd
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine O'Neill
15. Birthplace New York

16 (a) Informant Miss Mary E. Lowd.
(b) Address 1840 W. Baltimore

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/30/1944 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location 4300 blk Frederick Road

18 (a) Funeral director John J. Gowan & Son
(b) Address 844-846 Gilmor St.

19 (a) MAR 29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to March 28 1944, and that I last saw h ER alive on March 27 1944.

Immediate cause of death Hypertensive C.V. disease — Duration 2 yrs
Due to Generalized arteriosclerosis — 10 yrs
Due to ...
Other Conditions ...
(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operations: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury ...

23. Signature John F. Coolahan M. D.
Address 24 N. Fulton Ave Date signed 3/28/44

VS 180

G 15642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15642 Registered No. 1218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 N. Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16'

(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 N. Bentalou St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret F. Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Harry M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1898

8. AGE: Years 45 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Flintstone, Md (town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Chas. J. Robasson
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth S. Robasson
15. Birthplace Scotland

16 (a) Informant Miss Helen E. Foster
(b) Address 833 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location 3501 Frederick Rd

18 (a) Funeral director Harry A. Little
(b) Address 4101 Edmondson Ave

19 (a) Huntington Williams, Registrar
(Date received by registrar)

MAR 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/44 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1943 to March 26 1944, and that I last saw h[illegible] alive on March 25 1944.

Immediate cause of death: Chronic Nephritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Fisher M. D.

Address 1843 N. Wash. St. Date signed 3/28/44

VS 180

G 15643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G 15643

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mercy Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 400 Patapsco Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Frank J. Martin Sr

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Mary Martin

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) July 4 1887

8. AGE: Years 56 | Months 8 | Days 23 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation millwright.

11. Industry or business Steel.

FATHER 12. Name Lewis Martin

13. Birthplace Germany.

MOTHER 14. Maiden Name Kathrina Brecht

15. Birthplace Unknown

16 (a) Informant Hosp Records

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 30/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.

(b) Address 403 S. WOLFE ST.

MAR 29 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1944 to March 27 1944 and that I last saw h / alive on March 27 1944

Immediate cause of death Cardio Resp. failure — Duration 1 Day

Due to Terminal Pneumonia — Duration 1 day

Due to Arteriosclerotic CVD — Duration ?

Other Conditions Alcoholism. Cachexia.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Carlton Weed M. D.

Address Mercy Hosp Date signed 3-27-44

VS 150

G 15644

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927

G 15644
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Soukup

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widower

6 (b) Name of husband or wife Emma Soukup
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	8	27		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Florist
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Charles Soukup (Son)
(b) Address 2713 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Edgerton Ave. Ext.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 402 S. Wolfe St.

19 (a) MAR 29 1944 Huntington Williams, M.D. (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1944, at 8:25 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h:s death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease &
Chronic Myocarditis
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Charles Sulzenko M.D. Medical Examiner.
Date signed 3/29/44

VS 181

G 15645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 15645

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 521 Mason St.

(c) Hospital or institution: Md. Gen. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 521 S. Mason St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Carroll S. Lange

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-6747

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	[redacted]

6 (b) Name of husband or wife Vera V. Lange

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1893

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	8	28		

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Kiln Operator

11. Industry or business Furniture Factory

FATHER

12. Name Robert Lange

13. Birthplace Germany

MOTHER

14. Maiden Name [illegible]

15. Birthplace Maryland

16 (a) Informant [redacted] Vera Lange

(b) Address 521 S. Mason St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Lilly Zeller Mc

(b) Address 407 S. Wolfe st

19 (a) [illegible] (Date received by registrar) (b) Huntington Williams Registrar

MAR 29 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 19 44, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 19 44, to 3/29 19 44.

and that I last saw h[illegible] alive on 3/29 19 44.

Immediate cause of death Uremia Lacunar

Due to Blockage of ureters + bladder by crystals

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Earl Myers M.D.

Address Md. Gen. Hosp. Date signed 3/29/44 M. D.

G 15646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15646 Registered No. 1572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1122 Newcombway

(c) Hospital or institution: Armist Gardens

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days

(e) Length of stay in Baltimore (yrs., mos., or days) 16days

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1122 NEWCOMBWAY (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter E Gensler

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: child

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/44

8. AGE: Years | Months | Days: 16 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Clair E Gensler

13. Birthplace Altoona Pennsylvania

MOTHER 14. Maiden Name Janet Campanara

15. Birthplace Altoona Pennsylvania

16 (a) Informant Janet Gensler (mother)

(b) Address 1122 Newcombway Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/29/44 (month) (day) (year)

(c) Cemetery or crematory Sacred Hearts

Location German Hill Road Balto Co

18 (a) Funeral director Lilly & Zeller or

(b) Address 403 S. Wolfe St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1944, at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25 1944. to Mar. 27 1944. and that I last saw him alive on Mar. 27 1944.

Immediate cause of death: Septicaemia — Duration: 10 Days

Due to Syringo Myelocele — 2 Wks 3 Days

Due to Cause unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Amelia C Link

Address 2211 6 Lake

Date signed 3/29/44 M. D.

G 15647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15647 Registered No. 129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Madison avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Keeto.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Married.

6 (b) Name of husband or wife Harry Keeto
6 (c) If alive, give age — years
7. Birth date of deceased mo., day, yr Feb. 22, 1885

8. AGE: Years	Months	Days	If less than one day
59	1	5	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Unknown.
FATHER 13. Birthplace
MOTHER 14. Maiden Name Unknown
MOTHER 15. Birthplace

16 (a) Informant Husband.
(b) Address 2218 Madison avenue.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director James A Stayes
(b) Address 1142 W Fayette St
19 MAR 29 1944 (b) Huntington Williams, M.D. Registrar
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-44 19 , at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1944 to 3-27 1944.
and that I last saw her alive on 3-27 1944.

Immediate cause of death Respiratory failure.
Due to Generalized Peritonitis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 3-25-44
Major findings of operation: Generalized peritonitis
autopsy: Gen. Peritonitis

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature P. P. Ziegler M. D.
Address Mercy Hosp. Date signed 3-28-44

G 15648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G 15648

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 23rd & Calvert St.

(c) Hospital or institution: Union Memorial Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr. 6 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore.

(c) City or town Baltimore - 10. (If outside city or town limits, write RURAL and give town)

(d) Street No. 4212 Wickford Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ~~Mrs Thomas Jefferson~~ O'Donnell (Kathrine D.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Thomas J. O'Donnell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July - 1858

8. AGE: Years	Months	Days	If less than one day
85	9	—	— hr. — min.

9. Birthplace Missouri (Town, county, and state)

10. Usual Occupation none

11. Industry or business none.

FATHER

12. Name William Dwyer

13. Birthplace Missouri.

MOTHER

14. Maiden Name Elizabeth Canton.

15. Birthplace New Orleans, La.

16 (a) Informant Mrs. O. Gordon Daly

(b) Address 4212 Wickford Road

17 (a) (Burial, cremation, or removal) (b) Date thereof 3/30/44 (month) (day) (year)

(c) Cemetery or crematory Denver, Colorado

Location

18 (a) Funeral director H. W. Mears & Son

(b) Address 805 N. Calvert St.

MAR 28 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944, at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1944, to March 28 1944, and that I last saw her alive on March 28 1944.

Immediate cause of death	Duration
cardio-respiratory failure.	
Due to toxemia -	1 d.
Due to bilateral broncho-pneumonia	1 d.
Other Conditions fract. rt. hip. arteriosclerotic ht. disease. (Include pregnancy within 3 months of death)	8 d.

Date of operation none.

Major findings of operation: none.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence March 21, at M

(c) Where did injury occur? home. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no

(e) Means of injury fell on steps

23. Signature Thomas R. Chipelle M. D.

Address Union Mem. Hosp. Date signed

For C. J. Lubinski, by Howard S. Mussen, MD 3/28/44

15649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G 15649
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITEL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 S. Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Steven Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	widowered

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 - 20 - 78

8. AGE: Years	Months	Days	If less than one day
65	4	2	hr min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Earli Clark
13. Birthplace

MOTHER
14. Maiden Name Sallie
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITEL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 29 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (Date received by registrar) MAR 29 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1944 at 3 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 16 1944 to Mar 22 1944 and that I last saw h[illegible] alive on Mar 22 1944.

Immediate cause of death ? heart failure — Duration

Due to P.O. Thrombosis

Due to Ca of esophagus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/21/44

Major findings of operation:

Autopsy: Surgical Ca esophagus

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George L. Hayes, M.D.
Address Johns Hopkins Hosp Date signed 3/27/44

VS 180

0835

G 15650

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 81a

G 15650 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D Mun
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS HOSP. MAR 2 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 2 1944 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 6:58 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH purulent meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 28, 1944

0834

G 15651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83B Registered No. G 15651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Sweeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 29 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 29 1944 Huntington Williams
(Date rec'd by registrar) Registrar

VS 151

0833

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infarct of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 23 1944

G 15652

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15652 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Penrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Penrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia A. Hunter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Phillip M. Hunter
6 (c) If alive, give age 1857 years

7. Birth date of deceased (mo., day, yr.) June 12, ~~1858~~

8. AGE: Years	Months	Days	If less than one day
86 ~~85~~	9	16	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER | FATHER
12. Name Joshua Lockard
13. Birthplace Westminster, Md.
14. Maiden Name Julia Beaver
15. Birthplace Westminster, Md.

16 (a) Informant Miss Olive Hunter
(b) Address 1807 Penrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Willis Lamotray
(b) Address 4510 Liberty Heights Ave.

19 (a) MAR 29 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944, at 6.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1944, to 3-28 1944, and that I last saw her alive on 3-28 1944.

Immediate cause of death Hypertensive Cardio vascular Disease — Duration 2 years
Due to
Due to
Other Conditions none

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operations none
of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George E. Bungtorf M. D.
Address Ellicott City, Md. Date signed

(over)

G 15653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15653 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 546 McMechen ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha L. Hayes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-18-'08

8. AGE: Years 35 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Durham, N. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Rufus Hayes
13. Birthplace N. C.

MOTHER
14. Maiden Name Annie Leathers
15. Birthplace N. C.

16 (a) Informant Annie Leathers
(b) Address 546 McMechen St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-44 (month) (day) (year)

(c) Cemetery or crematory
Location Durham, N. C.

18 (a) Funeral director Chas. R. Law
(b) Address 802 Madison Ave.

19 (a) (Date) (b) Registrar

MAR 29 1944
VS 150

Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1944, to March 28 1944, and that I last saw h er alive on March 28 19 44.

Immediate cause of death Hypertensive Heart Disease — Duration

Due to

Due to

Other Conditions Chronic Myocarditis a Decompensation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. H. Bayne, M.D.
Address Provident Hospital Date signed 3/29/44

15654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15654
Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6622 Belford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6622 Belford Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Non-viable infant Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Wh

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: hr. 15 min.

9. Birthplace 6622 Belford Ave.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Frank Wilson
13. Birthplace Baltimore City

MOTHER
14. Maiden Name Bernice Marie Parks
15. Birthplace Baltimore City

16 (a) Informant Mrs. Joseph F. Wilson
(b) Address 6622 Belford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 29 44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Gdns.
Location Balto. Co. Md

18 (a) Funeral director Lorraine Funeral Home
(b) Address 7701 Belair Rd.

19 (a) MAR 29 1944 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 28th 1944, at 12.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 , and that I last saw h alive on 19 .

Immediate cause of death
Prematurity
(stage of gestation 5-5½ mos.)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M.D. M. D.
Address 5713 Bel Air Rd. Date signed 3-29-44

VS 3

G 15655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15655 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 736 S. Charles Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Shelby L. Hensley

3 (b) If veteran, name war —

3 (c) Social Security Account No. 244-24-9162

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1891

8. AGE: Years 52 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Millhaven N. C (Town, county, and state)

10. Usual Occupation Ship fitter

11. Industry or business Shipyard

FATHER
12. Name Jasper Hensley
13. Birthplace N. C

MOTHER
14. Maiden Name Lilla
15. Birthplace N. C

16 (a) Informant Family
(b) Address 736 S. Chas.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory
Location Greenmount N. C

18 (a) Funeral director Thos. J. Kenny
(b) Address Hollins & Gilmor

19 MAR 29 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1944, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature N. F. Wallenmeyer M.D. Medical Examiner.
Date signed March 28, 1944.

VS 151

G 15656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15656 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4006 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard F. Irwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	divorced

6 (b) Name of husband or wife Lena Mae Irwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1871

8. AGE: Years	Months	Days	If less than one day
72	3	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Expressman
11. Industry or business Express

FATHER
12. Name James L. Irwin
13. Birthplace Newburg, N. Y.

MOTHER
14. Maiden Name Laura V. Wheeler
15. Birthplace Reisterstown, Md.

16 (a) Informant Miss Lillian Irwin
(b) Address 4006 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave.

19 (a) 3-29-1944 (Date received by registrar) (b) Hunting & Wilson Embalmer

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1944, at 2:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18 1944 to Mar. 28 1944 and that I last saw him alive on Mar. 28 1944

Immediate cause of death Pulmonary Tuberculosis (Tuberculosis) — Duration years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving S. Akehurst M. D.
Address 4007 Park Heights Ave Date signed 3-29-44

VS 100

G 15657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15657 / 123

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 3/18/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1908

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Elsinore Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES MOORE CLARK

3 (b) If veteran, name war	3 (c) Social Security Account No.
World's War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1897

8. AGE: Years	Months	Days	If less than one day
46	7/0	22	hr. min.

9. Birthplace Wilmington, Del. (Town, county, and state)
10. Usual Occupation Ins. salesman
11. Industry or business -

FATHER
12. Name Sam. B. Clark
13. Birthplace Yorklyn, Pa.

MOTHER
14. Maiden Name Margaret F. Moore
15. Birthplace Galesville, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Loring Bogue.
(b) Address 5005 Park Heights Ave.

19 (a) Date received (b) Registrar
MAR 29 1944
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH March 28, 1944 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18, 1944 to Mar. 28, 1944 and that I last saw him alive on Mar. 28, 1944

Immediate cause of death Acute gastro intestinal hemorrhage, cause undetermined — Duration: 5 wks.

Due to — Duration: of illness prior to hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury

23. Signature H. Clarke, M. D.
Address Baltimore, Md. Date signed 3/28/44

Va-14373

G 15658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 15658 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 N. Stricker
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 907 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) V
If yes, name country

3 (a) **FULL NAME** Estelle M. Walker V

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4 Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/9/1866

8. AGE: Years 77 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John C. Conkling
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Sarah Bridge
15. Birthplace Baltimore, Md.

16 (a) Informant Elizabeth Cyler
(b) Address 902 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30, 1944 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee H. Hyland
(b) Address 1631 Druid Hill Ave.

MAR 30 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 26 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18 1944 to Mar. 26 1944, and that I last saw h alive on Mar. 24 1944.

Immediate cause of death Bronchopneumonia — Duration 1 week

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Redding, M. D.
Address 426 N. Johnson Date signed 3/29/44

VS 150

15659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15659 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution: Crawford Retreat-Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Pentridge Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie R. Rider

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) July 10th 1861

8. AGE: Years: 82 | Months: 8 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: Edward Rider
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Rebecca A. McConkey
15. Birthplace: Balto. Co. Md.

16 (a) Informant: John McC. Mowbray
(b) Address: 4810 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/30/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Balto. Md.

18 (a) Funeral director: William Cook
(b) Address: 127 St. Paul Place

19 (a) MAR 30 1944 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 27th 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1944 to March 27 1944 and that I last saw her alive on March 27 1944

Immediate cause of death: Lobar pneumonia — Duration: 7 days

Due to:

Due to: Lobar pneumonia — 7 days

Other Conditions: Advanced arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Hallie S. Hubbard M. D.
Address 2220 Garrison Blvd Date signed March 28/44

G 15660

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 D

Registered No. G-15660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3408 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

1546

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 345 N. Beaumont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CARRIE BLANCHE LEITCH

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	Female	White	Widow

6 (b) Name of husband or wife Harry Martin Leitch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1864

8. AGE: Years	Months	Days	If less than one day
80	2	25	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Wolfe Brady
13. Birthplace Mass.

MOTHER
14. Maiden Name Martha W. Mason
15. Birthplace Balto., Md.

16 (a) Informant Mr. James W. Leitch
(b) Address 2700 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 30 1944 Huntington Hilleary, M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Mar. 28, 1944, at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1944, to 3-28 1944, and that I last saw her alive on 3-25 1944.

Immediate cause of death	Duration
Cerebro-vascular accident	1/2 hr.
Due to arteriosclerotic cardiovascular disease	?
Due to	
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Herbert, Jr. M. D.
Address 1115 St. Paul St. Date signed 3-30-44

G 15661 G 15661

BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd.
(c) Hospital or institution: Shriner Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Hilton Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN OLIVER McLAUGHLIN

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1863

8. AGE: Years	Months	Days	If less than one day
80	4	17	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business

FATHER
12. Name William McLaughlin
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Sturgis,
15. Birthplace Md.

16 (a) Informant Mr. Wm. G. McLaughlin
(b) Address 2204 Kentucky Ave. 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) Registrar

MAR 30 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 28, 1944, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10-1943 to 3-28-1944 and that I last saw him alive on 3-26-1944.

Immediate cause of death: Apoplexy — Duration 6 days
Due to Arteriosclerosis — Duration Indefinite
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Tyler M. D.
Address 1102 Harford Ave. Date signed 3-28-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15662

Registered No. 93D

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1816 W. Lexington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1816 W. Lexington St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MARGARET NORA ABBOTT

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Joel J. Abbott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1859

8. AGE: Years	Months	Days	If less than one day
84	10	15	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William B. Turner

13. Birthplace Balto.

MOTHER 14. Maiden Name Louisa S. Brotherton

15. Birthplace Baltimore

16 (a) Informant Mrs. Thales Disney

(b) Address 1816 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1944, at 9:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 20 1944, to Mar. 28 1944, and that I last saw h-r alive on Mar. 27 1944

Immediate cause of death

Due to Chr. Myocarditis

Due to Laryngitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1935
3/20/44

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jane Brown M. D.

Address 1603 W. Rock E. Date signed 3/31/44

G 15663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G 15663

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 E 25th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Kingsway Rd (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME SOPHIA STROBEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Edward Strobel
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 26, 1874

8. AGE: Years	Months	Days	If less than one day
69	8	2	hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick W. Brochman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Christina H. Lauterbach
15. Birthplace Balto., Md.

16 (a) Informant Mr. Arthur Shaw, son-in-law
(b) Address 1625 Kingsway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MAR 30 1944

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944 at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1944 to ..... 19 ..., and that I last saw h alive on Mar 28 1944.

Immediate cause of death: Arteriosclerotic cardiovascular disease — Duration: 8 yrs.

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy .....

PHYSICIAN
Underline th cause to whic death should b charged statis tically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in publi place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature H. L. Wallenmeyer M. D.
Address Medical Arts Bldg Date signed 3-30-44

G 15664

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 82a

G 15664
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2434 Barclay St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2434 Barclay St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mary Rose White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Edward A. White
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1870

8. AGE: Years	Months	Days	If less than one day
74	2	16	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Benjamin F. Kenly
13. Birthplace Md.

MOTHER
14. Maiden Name Mary F. Murphey
15. Birthplace Md.

16 (a) Informant Mrs. Maud Jenkins
(b) Address 2434 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery ~~or Crematory~~ Lorraine
Location Windsor Mill Road, Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Signature of registrar) (b) Registrar

MAR 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1944, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1927, to Mar. 29, 1944 and that I last saw her alive on Mar. 29, 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: Immediate

Due to Hypertension — Duration: ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Ogden, M. D.
Address 2701 N. Calvert St. Date signed

G 15665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15665 ✓ 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3600 Ash St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Ash St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard T. Poe.

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White.	Widower.

6 (b) Name of husband or wife Mary J. Poe.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1854

8. AGE: Years	Months	Days	If less than one day hr.	min.
89	9	24		

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business Stone Quarry

FATHER
12. Name John Poe.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Bessie M. Bode.
(b) Address 3600 Ash St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 31, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Texas, Md.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3645 Chestnut Ave.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) MAR 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to MARCH 28 1944, and that I last saw H.M alive on MARCH 28 1944.

Immediate cause of death Myocardial degeneration
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 10 days / 15 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Davies M. D.
Address 810 W 33rd St Date signed 3-29-44

G 15666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G 15666

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3365 Chestnut Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3365 Chestnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Franklin Parker.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1944

8. AGE: Years | Months | Days: 27 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John O. Parker.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Frances L. Kelly.
15. Birthplace South Carolina.

16 (a) Informant John O. Parker.
(b) Address 3365 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31/44 (month) (day) (year)

(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Eichenlaub & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) MAR 30 1944 (Date rec'd by registrar) Huntington Hitchcock Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1944 at 6.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1944 to March 29 1944. and that I last saw him alive on March 29 1944.

Immediate cause of death: Acute Gastro-enteritis — Duration: 8 days
Due to: Neonatorum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Wilson

Address 617 N. 40th St Date signed 3/29/44 (M. D.)

VS 180

G 15667

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 15667

CERTIFICATE OF DEATH 131B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Cario St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 +
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Cario St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Dillard

3 (b) If veteran, name war No
3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/6/1863

8. AGE: Years 81 | Months — | Days 20 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Lewis Dillard.
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant Mrs Annie Clark.
(b) Address Alexandria, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Chas Gorsuch
(b) Address 512 Cathedral St.

19 (a) (b)

MAR 30 1944 Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/44 19 at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 19 44 to 3/26 19 44
and that I last saw h[illegible] alive on 3-21 1944.

Immediate cause of death: Nephritis — Duration: 1 mo
Due to: Uremia
Due to: Acute Retention
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas Shepperd M.D.
Address 1431 W Franklin St Date signed 3/30/44 M. D.

G 15668 ✓ G 15668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 E. Balto. St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Levy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day hr.	min.
57 yrs 6 mos				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Henry Growett
(b) Address 1433 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Philadelphia Rd & Bowleys Lane

18 (a) Funeral director Jack Davis Inc
(b) Address 1439 E. Balto St

19 (a) MAR 30 1944 (Date received by registrar)

Huntington Undertaking Co

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 30 1944, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1944, to Mar 30 1944, and that I last saw h alive on Mar 28 1944

Immediate cause of death Acute Cardiac dilatation — **Duration**

Due to Mitral stenosis Chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S C Feldman

Address 1440 E Balto St Date signed 3/30/44 M. D.

VS 180

(OVER)

G 15669

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 15669

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto. - Townsend
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Hammonds Ferry Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Goldberg

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Isidore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1900

8. AGE: Years	Months	Days	If less than one day hr.	min.
43	5			

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER	12. Name Barney
	13. Birthplace Russia
MOTHER	14. Maiden Name Rachael
	15. Birthplace Russia

16 (a) Informant Husband.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hy & Hamilton Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date received by registrar) 1944 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1944, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944, to Mar 29 1944, and that I last saw her alive on Mar 29 1944.

Immediate cause of death: Pulmonary Edema — Duration

Due to metastatic carcinoma

Due to carcinoma of breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Hellan M. D.
Address Sinai Hosp Date signed 3/29/44

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 150

15670

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G 15670
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 S. Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days 20
(e) Length of stay in Baltimore yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(d) Street No 626 S. Monroe St
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME William H. Filling

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-1259

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ellen A Filling
6 (c) If alive, give age — years

20. DATE OF DEATH Mar 27 1944, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1943 to Mar. 27 1944 and that I last saw h I M alive on MAR. 26 1944

7. Birth date of deceased mo., day, yr June 2nd 1906

8. AGE: Years 38 Months 2 Days 6 If less than one day hr min

9. Birthplace Baltimore, Md. (town, county and state)

10. Usual Occupation Clerk
11. Industry or business L. A. Benson Co

FATHER 12. Name	Wm. H. Filling
13. Birthplace	Md
MOTHER 14. Maiden Name	Rosa Schmidt
15. Birthplace	Md

16 (a) Informant Ellen A. Harding Filling
(b) Address 626 S. Monroe St

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Mar 30/44 (month, day, year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore, Md.

18 (a) Funeral director F. O. Tippett Son
(b) Address 850 W. Baltimore St

19 (a) MAR 30 1944 (b) Registrar

VS 150

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Malignant Hypertension	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town, County, State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
(f) Signature Geo Pound
Address 400 N Fayon Date signed 3/29/44 M D

PHYSICIAN
Underline the cause to which death should be charged statistically

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

Registered No. G 15671

G 15671

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2526 Mc Henry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days 20 -

(e) Length of stay in Baltimore yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED:

a. State Md b. County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

d. Street No. 2526 Mc Henry St

(If rural give road and box number)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) **FULL NAME** Charles Schuller

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary E Schuller

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 25 - 1862

8. AGE: Years 8/ | Months 7 | Days 4 | If less than one day hr min

9. Birthplace (Town, county, and state) Baltimore. Md

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Ernest Schuller

13. Birthplace Germany

MOTHER 14. Maiden Name Caroline Kuhl

15. Birthplace Germany

16 (a) Informant H. E. Schuller

(b) Address 2526 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) April 1/44

(c) Cemetery or crematory London Park.

Location Baltimore. Md

18 (a) Funeral director F. B. Wippert Son

(b) Address Baltimore. Monroe St

19 (a) (Date received by registrar) MAR 31 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1944 at 4 P M

21. I certify that death occurred on the date above stated, that I attended deceased from March 20 1944, to March 29 1944, and that I last saw h alive on March 27 1944

Immediate cause of death	Duration
Myocardial insufficiency	2 wks
Due to Senility & general arterio sclerosis. —	5 or 6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City, town, County, State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify which)

(e) Means of injury

23. Signature M Bunn and Lord M. D.

Address 2200 Garrison Blvd Date signed 3/29/44

G 15672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 15672

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 653 Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 653 Vine St (If rural give location)
(e) Citizen of foreign country? Yes or No)
If yes, name country

3 (a) FULL NAME Sterling Goodman

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex M.

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1902

8. AGE: Years 41 Months 3 Days 6 If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name George W. Goodman
13. Birthplace Va

MOTHER
14. Maiden Name Laura Kelly
15. Birthplace Va

16 (a) Informant Charles Savage
(b) Address 653 Vine St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location L. A. County. Md.

18 (a) Funeral director Joseph B. Cook & Son
(b) Address 304 N. Central Ave

19 (a) MAR 30 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 29 1944 at 9 45 AM

21. I certify that death occurred on the date above stated, that I attended deceased from March 29 1944 March 29 1944 and that I last saw h alive on 3/29 1944

Immediate cause of death Lobar Pneumonia

Duration 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 419 Dugan Ave Date signed 3/30/44 M D

VS 3

G 15673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G 15673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 E 30th St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sue Ann Nixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr

8. AGE: Years 4 | Months | Days | If less than one day hr min

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mother
(b) Address 405 Belmont Place

17 (a) Buried (Buried, cremation, or removal) (b) Date thereof 3-30 (month) (day)
(c) Cemetery or crematory Lakewood
Location Baltimore Md

18 (a) Funeral director Carroll Funeral Home
(b) Address 3503 Eastern Ave

19 (a) MAR 30 1944
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 19 44, at 5 P M

21. I certify that I took charge of the remains described above, held an Autopsy-Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident , suicide , homicide , undetermined and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hydrocephalus
Spina Bifida

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary or contributing cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Peter J. Sulnick M.D.
Medical Examiner
Date signed 3/28/44

VS 151

G 15674

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15674 Registered No. 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walkers mfg Calow Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 135 Abbott court (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Katherine A Hughes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-9-1875

8. AGE: Years	Months	Days	If less than one day
68	3	20	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation seamstress
11. Industry or business Sanchez Isaacment Co

FATHER
12. Name Timothy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Nolan
15. Birthplace

16 (a) Informant F A Hughes
(b) Address 2208 Hamlet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-44 (Months)
(c) Cemetery or crematory Cathedral
Location Route

18 (a) Funeral director Leonard C Wright
(b) Address 1505 Harford

19 (a) MAR 30 1944 (b) (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1944 at 12:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1944 to 3-29 1944, and that I last saw her alive on 3-29 1944

Immediate cause of death Massive Pulmonary Embolus — Duration

Due to Medical Mastectomy

Due to for Carcinoma of Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-15-44

Major findings of operation: Carcinoma of Left Breast. Metastic to Massive Pulmonary Emboli

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
(f) Signature W E Machen M.D.
M. D.

Address St. Agnes Date signed 3/29/44

PHYSICIAN
Underline the cause to which death should be charged statistically

G 15675

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92 E

G 15675
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 S. Caroline st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. yrs., mos., or days 3
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write (R) RAL and give town)
(d) Street No. 522 S. Caroline St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Andrew Harris
3 (b) If veteran, name war
3 (c) Social Security Account No. —
4. Sex M.
5. Color or race Col.
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 15, 1890
8. AGE: Years 54 Months — Days 14 If less than one day hr min
9. Birthplace Middlesex Co. Va.
(Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Annie Taylor
(b) Address 522 S. Caroline St
17 (a) Burial (b) Date thereof 3/31/44
(Burial, cremation, or removal) (Month, day, year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Elgar O. Wilson
(b) Address 1000 Broadway Ave
19 (a) (b) Registrar
MAR 30 1944
VS 150
Hunting Ave Pikesville, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/44 19 at 750A M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1944 to 3/24 1944 and that I last saw him alive on 3/27 1944

Immediate cause of death Pulmonary Failure — Duration

Due to Congestive Heart Failure

Due to Contusion Hypostasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Emmett R. Julian
Address 434 E. 23rd St. Date signed 3/24/44

PHYSICIAN
Underline the cause to which death should be charged statistically

G 15676

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121a

G 15676
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 253 N. Eaton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Allan Weaver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 23, 1906

8. AGE: Years 37 | Months 11 | Days 4 | If less than one day: hr min

9. Birthplace Prince Edward Co. Va. (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Edward Weaver
13. Birthplace Va

MOTHER
14. Maiden Name Maddie Hayes
15. Birthplace Va.

16 (a) Informant Hattie Redd
(b) Address 100 N. Medeira St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley Ave

19 (a) MAR 31 44 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944, at 8:45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebro vascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fontaine M.D. (Medical Examiner)
Date signed March 27, 1944

VS 151

G 15677 — 29/15

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15677 Registered No. — 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution:
If not in hospital give street address or location) St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1646 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mrs Daisy Bm Heinlein
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14-1944

8. AGE: Years | Months | Days | If less than one day: hr. min
5

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name George Heinlein
13. Birthplace

MOTHER 14. Maiden Name Daisy B Millsler
15. Birthplace Md.

16 (a) Informant St. Agnes Hosp.
(b) Address Wilkens & Caton Aves

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 30/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine St.
Location

18 (a) Funeral director John L. Mills
(b) Address 2334 Jefferson St.

19 (a) Date received by registrar MAR 30 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 29 1944 at 7 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/14 1944 to 3/29 1944 and that I last saw h / s alive on 3/29 1944

Immediate cause of death Pneumonia — Duration 15 Days

Due to

Due to Premature Birth

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury
(f) Signature A H Guyer M. D.
Address Date signed

G 15678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1443

G 15678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Thelma Bagley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Colored	Married

6 (b) Name of husband or wife James Bagley (c) If alive, give age 18 years

7. Birth date of deceased (mo., day, yr.) April 11, 1928

8. AGE: Years	Months	Days	If less than one day
15	11	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name James Mitchell
13. Birthplace Florida

MOTHER
14. Maiden Name Julia Mitchell
15. Birthplace Baltimore, Md.

16 (a) Informant James Bagley
(b) Address 802 S. Sharp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Md

18 (a) Funeral director David L Brown
(b) Address 108 W Montgomery St

19 (a) [illegible] (Signature of local registrar) Hilliard A. Wilson, M.D. Registrar

MAR 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/44 19 , at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1944 to 3/26 1944, and that I last saw her alive on 3/26 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Fulminating Eclampsia

Due to

Other Conditions Pregnancy - 32 wks.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel, M. D.
Address University Hospital Date signed 3/26/44

G 15679

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15679
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 Argonne Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 820 Argonne Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Bell Willis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Female	Black	Widowed

6 (b) Name of husband or wife Frank Willis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66	6	3		

9. Birthplace Kansas (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name George Manville
13. Birthplace Kansas

MOTHER
14. Maiden Name Not Available
15. Birthplace Kansas

16 (a) Informant J A Farley
(b) Address 11 E Madison St Hall Cor

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director George A Farley
(b) Address Fulton & Lafayette (b) Washington & Williams Sts

30 1944
(Date rec'd by registrar)

Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29- 1944, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-29-44

Copy not to be made unless it is especially important. Physicians: please write the causes of death clearly and legibly.

G 15680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 15680 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 S Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie F. STALLINGS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Henry L. Stallings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1867

8. AGE: Years	Months	Days	If less than one day
76	5	18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Wilkerson
13. Birthplace Maryland

MOTHER
14. Maiden Name Dont Know
15. Birthplace Maryland

16 (a) Informant James F. Stallings
(b) Address 1517 Eastern Ave - Essex Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

MAR 30 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944 at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1944 to 3/28 1944, and that I last saw her alive on 3/28 1944.

Immediate cause of death	Duration
Hypertensive C-V. disease	15 y.
Due to Generalized arterio sclerosis	
Due to Diabetes mellitus	15 y
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed Schumacher M. D.
Address 842 S. Eastern Date signed 3-29-44

15681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1442

G 15681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S. Clinton Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Katherine Sellers 31950

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Eldridge Sellers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1913

8. AGE: Years	Months	Days	If less than one day
30	9	25	15 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Henry J. Reif
13. Birthplace Maryland

MOTHER
14. Maiden Name Theresa Alers.
15. Birthplace Maryland

16 (a) Informant Dorothy Sellers.
(b) Address 101 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Eastern Ave.

19 (a) MAR 30 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/44 19 , at 4:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28/44 19 , to 3/29/44 19 , and that I last saw h alive on 3/29/44 19 .

Immediate cause of death Pulmonary edema — Duration

Due to Intoxicating eclampsia

Due to Toxemia of Pregnancy

Other Conditions Shock
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Clyde Webster, M.D.
Address Franklin Square Hosp. Date signed 4/2/44

VS 8

Approved by Howard J. Anderson, M.D.

Please write plainly. Use ink or indelible pencil. Do not use typewriter. Fill in all blanks by printing or writing in full the information desired, or by stating that the information cannot be obtained. Physicians: please write the causes of death clearly and legibly. Statements of conditions as the cause of death without explanatory supplemental statements are unacceptable. The space for "Length of residence" is especially important. Physicians: please write the causes of death clearly and legibly.

G 15682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15682 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Date of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Cresmont Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD FRANCIS TINNAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes M. Carroll
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 29, 1877

8. AGE: Years	Months	Days	If less than one day
66	9	0	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation --
11. Industry or business --

FATHER
12. Name James Tinnan
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Tulley
15. Birthplace Ireland

16 (a) Informant Records, U. S. Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director Chas. F. Evans-Son
(b) Address 118 W. Mt. Royal Ave

MAR 30 1944 (Signature of registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Mar. 29, 1944, at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 28, 1944, to Mar. 29, 1944, and that I last saw him alive on Mar. 29, 1944.

Immediate cause of death	Duration
Cardiac insufficiency	Unk.
Due to Arteriosclerotic heart disease	Unk.
Due to	
Other Conditions Nephrosclerosis; Uremia (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation:
of autopsy: None done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. S. Bean M. D.
Address Baltimore, Md. Date signed 3/29/44

P.653 - No. 52001

G 15683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170c

G 15683
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore, Maryland
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4640 Rokeby Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia B. Chester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife: Frederick S. Chester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1908

8. AGE: Years	Months	Days	If less than one day
35	-	21	hr. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: William R. Bowles
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Eva Shipman
15. Birthplace: Virginia

16 (a) Informant: Mr. Frederick Chester
(b) Address: 4640 Rokeby Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Balto. Md.

18 (a) Funeral director: Harry H. Weltze
(b) Address: 4104 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 30 1944

VS 351

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1944, at 8:05 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage, left pleural Cavity

Due to Hematoma of ruptured mediastinum.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-17-44 at 1:30 P. M.
(b) Where did injury occur? ~~N. Bound Brook~~ Intersection of Bellgrove & ~~Annapolis~~ Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public car While at work? No.
(d) Means of injury Struck telephone pole.

23. Signature Henry L. Wollenweber, M.D.
Medical Examiner.
Date signed March 30, 1944

For Dr. H. L. Wollenweber, by Howard J. Mavris, M.D.

DOA
H.H. Disp.

G 15684 BALTIMORE CITY HEALTH DEPARTMENT X G 15684
CERTIFICATE OF DEATH V38E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Govans Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7315 Betz Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Jean Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. child
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-28-44 43
8. AGE: Years Months 7 Days - If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Oscar W. Johnson
13. Birthplace Va.
MOTHER 14. Maiden Name Margaret Forbs
15. Birthplace Va.
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.
18 (a) Funeral director Harry A. Wiltz
(b) Address 4101 Edmondson Ave.
19 (a) (Date received) MAR 30 1944 (b) Registrar Williams M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH March 28 19 44 at 3 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25 19 44 to Mar 28 19 44 and that I last saw h[illegible] alive on Dead on Arrival
Immediate cause of death Pneumonia — Duration 9 da
Due to Chicken Pox — 9 da
Due to
Other Conditions Malnutrition
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Pneumonia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Isabella Conrad M. D.
Address Johns Hopkins Hosp. Date signed 3-29-44

VS 180

G 15685
AB-86455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 15685
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos.-15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Sanders St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Driscoll

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13-1865

8. AGE: Years	Months	Days	If less than one day
78	5	16	hr min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter W. Doman
13. Birthplace ?

MOTHER
14. Maiden Name Mary Elizabeth Seward
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-31-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd.

18 (a) Funeral director Jos. F. McCarthy
(b) Address 1030 E. Fort Ave.

19 (a) 1044 (Registered by registrar) (b) Huntington for Williams Registrar

MAR 30 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/44 19 . at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18/44 19 . to 3/29/44 19 , and that I last saw h-er alive on 3/29/44 19 .

Immediate cause of death: Generalized Arteriosclerosis
Arteriosclerotic C V D.

Duration

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Multiple pulmonary emboli

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl R. Kinney
Address B C H
M. D.
Date signed 3/29/44

15686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1320

G 15686 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 - Forrest St.
(c) Hospital or institution: Md. Penitentiary Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 - No. Stricker St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Cole

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1920

8. AGE: Years	Months	Days	If less than one day
23	10	25	27 hr. min.

9. Birthplace Mc Cormick, So. Car. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Marshall Cole
13. Birthplace So. Carolina

MOTHER
14. Maiden Name Angie Brown
15. Birthplace So. Carolina

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL MAR 30 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 30 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1944, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1944, to March 20 1944, and that I last saw h-m alive on March 20 1944

Immediate cause of death: Tuberculous pneumonia — Duration
Due to: Pulmonary tuberculosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C F Kares M. D.
Address Md. Pen. Hospital Date signed 3-20-44

VS 250

0837

G 15687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

G 15687 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Green Sts.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3902 Hadley Sq. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew E. Sable

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Male	W.	Married

6 (b) Name of husband or wife L. Myra Sable
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1885

8. AGE: Years	Months	Days	If less than one day
58	5	11	hr. min.

9. Birthplace Yonkers N. Y. (Town, county, and state)
10. Usual Occupation Instructor
11. Industry or business Polytechnic Institute

FATHER
12. Name Andrew Sable
13. Birthplace Europe

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant L. Myra Sable
(b) Address 3902 Hadley Square

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Lewisburg Pa.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 30 1944 (Date rec'd by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29-1944, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1944, to 3-29 1944, and that I last saw him alive on 3-29 1944

Immediate cause of death: Internal asphyxation — Duration

Due to Bilateral Dermoid cysts of Mediastinum

Due to

Other Conditions Exhaustion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Range M. D.
Address Univ Hosp. Date signed 3-29-44

JO #74461 G 15688

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15688
Registered No. 1228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 9mos. 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 841 Park Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James Connolly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1863

8. AGE: Years	Months	Days	If less than one day
80	4	2	hr min

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Thomas Connolly
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth McKennea
15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 31 44 (Month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1318 Light St

19 (a) ~~Mar 30 1944~~ Huntington Hillsmere, Md

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1944, at 12:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1942, to 3/20 1944 and that I last saw h(im) alive on 3/30 1944.

Immediate cause of death: Volvulus of gut with strangulation — Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Matzman M. D.
Address B.C.H. Date signed 3/30/44

G 15689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 15689 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 N. Carrollton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie B. Kane

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Michael Kane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1881

8. AGE: Years	Months	Days	If less than one day
62	6	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home.

MOTHER / FATHER
12. Name unknown
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. Michad Kane
(b) Address 17 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 Old Frederick Rd.

18 (a) Funeral director Harry A. Wilke
(b) Address 1916 Edmondson Ave.

19 (a) 3 31 1944 (Delivered to registrar) (b) Livingston Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1944 to 3-27-1944 and that I last saw her alive on 3-27- 1944.

Immediate cause of death
Due to
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration
Years
3/28/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John J. Morrissey M.D.
Address 3632 Roland Ave Date signed 3/28/44

15690

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 1210 Reg. Dist. No.

15690

1. PLACE OF DEATH:

County

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 Mos

Hospital, institution, or street address where death occurred: 1711 Patapsco St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1711 Patapsco St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rosa E. Bell

3.(b) Social Security Number

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Mc Bell

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 10 1874

8. AGE: Years: 69 Months: 11 Days: 11 If less than one day: 20 hrs. ____ min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Joseph F. Embert
13. Birthplace: Virginia

MOTHER
14. Maiden name: Margaret A. Bagsent
15. Birthplace: Virginia

16. Informant: Mrs Eula Rubinow
Address: Bryant Md

17. Burial (Burial, cremation, or removal) Date thereof: 4/3/44 (month) (day) (year)

Cemetery or crematory: Park Heights

Location: Baltimore Md.

18. Funeral director: C. H. Fultz & Bro

Address: Baltimore Md.

19. MAR 31 1944 (Date rec'd by registrar) 19. Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30th 1944 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 18th 1944 to March 30th 1944 and that I last saw h[illegible] alive on March 27th 1944

Immediate cause of death: Hypertensive Cardio Vascular renal disease — DURATION: 2 y

Due to: —

Due to: —

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harry Deibel M.D.
M. D. or other

Address: 1226 Hunden St Date signed: 3/30/44

G 15691
451602

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15691
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Johnstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Bedford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilmer Trepel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	WIDOWED

6 (b) Name of husband or wife Alice M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-85

8. AGE: Years	Months	Days	If less than one day
58	3	11	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation clerk
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Frederick Trepel
13. Birthplace Pa.

MOTHER
14. Maiden Name Oriana Walker
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 3/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Grandview
Location Johnstown Pa

18 (a) Funeral director William J. Jackson & Sons
(b) Address Main & Pennsylvania Aves

19 (a) MAR 31 1944 (b) Huntington Willis Littell, M.D.
Date received by registrar (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26 1944 to Mar. 30 1944, and that I last saw h[illegible] alive on Mar. 30 1944.

Immediate cause of death POST-OPERATIVE CEREBRAL OEDEMA — Duration

Due to

Due to

Other Conditions Carcinoma of Colon & Metastasis.
(Include pregnancy within 3 months of death)

Date of operation 3/28/44, 3/29, 3/30

Major findings of operation: Carcinoma of transverse colon - cerebral oedema

Autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lew W. Chambers M.D.
Address Johns Hopkins Hospital Date signed 3/30/44

15692 M51267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G 15692
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2734 Eutaw Pl (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Violette M. Schleisner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Sol Schleisner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-4-68

8. AGE: Years 75 | Months 5 | Days 25 | If less than one day: hr min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Samuel Mayer
13. Birthplace Germany

MOTHER 14. Maiden Name Fanny Kahnweiler
15. Birthplace France

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnenmoon Sons
(b) Address 1902 Eutaw Place

19 MAR 31 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 44 at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 19 44 to Mar 29 19 44 that I last saw h alive on Mar 29 19 44

Immediate cause of death: Pulmonary Embolism — Duration:

Due to Abdominal carcinoma with ascites

Due to

Other Conditions Arteriosclerotic cardio-vasc. disease; Obesity
(Include pregnancy within three months of death)

Date of operation 3-21-44; 3-28-44

Major findings of operation: 10 liters & 4 liters ascitic fluid

of autopsy: Not done

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Bunch M. D.
Address Johns Hopkins Hosp. Date signed 3-30-44

G 15693

AB-82342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 15693

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos-29days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 834 N. Fairmount Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1-1878?

8. AGE: Years	Months	Days	If less than one day
66?-78?	1 ?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unable to work

11. Industry or business

MOTHER / FATHER

12. Name Nick Hawkins (D)

13. Birthplace Maryland

14. Maiden Name Annie Scoggins (D)

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave

19 (a) MAR 31 1944 (b) Registrar

Huntington Hall

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1944, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1944, to 3/28 1944, and that I last saw h alive on 3/28 1944.

Immediate cause of death Bronchopneumonia — Duration ?

Due to Hypertensive cardio vascular disease — Duration ?

Due to Moderate dementia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mall M. D.

Address B.C.H. Date signed 3/29/44

G 15694

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

167

G 15694
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Gen. Hospital 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 832 Tyson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
World War I —	—	Male	Negro	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1896

8. AGE: Years	Months	Days	If less than one day
48	2		hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name Joe Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Christina Woods
15. Birthplace Md.

16 (a) Informant Mary Elizabeth Hawkins
(b) Address 832 Tyson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) MAR 31 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1944, at 9 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of aorta

Due to

Other Conditions Stab wounds of chest

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-19-44 at 8.35 P. M.
(b) Where did injury occur? 832 Tyson Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature Thomas J. Waldeis M.D.
Medical Examiner.
Date signed 3-20-44

VS 151

G 15695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 131a

G 15695 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 505 N. Colvin St

(c) Hospital or institution: 5-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 505 N. Colvin St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lillie Senft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Levi Senft

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28th 1872

8. AGE: Years	Months	Days	If less than one day
71	6	2	hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation At home

11. Industry or business Self

FATHER 12. Name Mary B. Kline

13. Birthplace Pa.

MOTHER 14. Maiden Name Margaret Hildebrandt

15. Birthplace Pa

16 (a) Informant Charles McKelvey

(b) Address 4367 Shannon Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Francis M. E. Church

Location Cockeysville Md.

18 (a) Funeral director William Cook Inc

(b) Address 121 St. Paul St

19 (a) MAR 31 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1944 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1944 to 3/30 1944, and that I last saw h[illegible] alive on 3/29 1944.

Immediate cause of death Cerebral Hemorrhage — Duration ?

Due to

Due to

Other Conditions Arteriosclerosis Cardiac Vascular Renal Disease ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jos. M. D. Bloom M.D.

Address 1206 E. Preston St Date signed 3/30/44

G 15696 ✓ G 15696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hospital 10-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State | (b) County Little Sister of Poor, Balto.
(c) City or town Mercy Villa (If outside city or town limits, write RURAL and give town)
(d) Street No. Belcona Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Miss Margaret Carroll

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 22nd 1867

8. AGE: Years	Months	Days	If less than one day
76	9	7	hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Joseph Carroll
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Allred
15. Birthplace Ireland

16 (a) Informant Little Sister of Poor.
(b) Address -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1st 1944 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Johns
Location Long Green Md.

18 (a) Funeral director Watkins Cook Inc
(b) Address St. Paul & Huntington Ave Williams Apt.

19 (a) MAR 31 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1944 at 11:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1944 to March 29 1944, and that I last saw her alive on March 29 1944.

Immediate cause of death	Duration
Bilateral Bronchopneumonia	?
Due to Fractured right hip	?
Due to fall	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence March 17, 1944 at 12 P. M
(c) Where did injury occur? 1200 Valley Street (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work? No
(Specify type of place)
(e) Means of injury Fell from table & fell on the floor.

23. Signature C. Ellsworth Cook, Jr. M. D.
Address Mercy Hospital Date signed 3-29-44

For O. R. Goodwin, by Howard Kaufman, M.D.

G 15697

G-87156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 15697 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Rochester Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Martin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5- 1904

8. AGE: Years	Months	Days	If less than one day
39	7	24	hr min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Acetylene Burner
11. Industry or business

FATHER
12. Name George A. Martin
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Grebing
15. Birthplace West Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5-44
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Edwin A. Phillips
(b) Address 3006 Bdo. St.

19 (a) (Date rec'd by registrar) MAR 31 1944 (b) Registrar Huntington Hillsdale, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1944, at 3:15 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 3/28 1944 to 3/29 1944, and that I last saw him alive on 3/29 1944.

Immediate cause of death Coronary Thrombosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Contributing cause (or condition) giving rise to immediate cause (a), (b), and (c), in order of importance

Was case referred to coroner? Was autopsy performed? Were findings of autopsy available?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman M.D.
Address 15 Ctt Date signed 3/30

G 15698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

Registered No. G 15698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 651 W Franklin st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d

(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mth

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 651 W. Franklin St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Junior Scott

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-25-44

8. AGE: Years | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Junior Scott

13. Birthplace N. C.

MOTHER 14. Maiden Name Elna Young

15. Birthplace N. C.

16 (a) Informant Junior Scott

(b) Address 651 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn cem Location Baltimore Md

18 (a) Funeral director Dilligan & Jackson

(b) Address 916 Penna ave

19 (a) 3-31-1944 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1944, to March 30 1944, and that I last saw h alive on March 29 1944.

Immediate cause of death Bronchitis — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —

(e) Means of injury —

23. Signature H. G. Stewart

Address 659 Franklin St Date signed M. 3 D. 31

G 15699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G 15699

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Wilkens & Caton Aves (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Sister Ambrose O'Dowd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1861

8. AGE: Years 82 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Catholic Nun

11. Industry or business

FATHER 12. Name Frank O'Dowd
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget McHugh
15. Birthplace Ireland

16 (a) Informant Hospital Record.
(b) Address Caton & Wilkens Aves.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 (month) 1 (day) 44 (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 N. North Ave.

19 (a) MAR 31 1944 (Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1944, to 3/30/44 19 ; and that I last saw h[illegible] alive on 3/30/44 19 .

Immediate cause of death: Lobar Pneumonia — Duration

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur Fosbrey M.D.
Address St. Agnes Hosp. Date signed 3/30/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15700 94a Registered No. 15700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 52 W. York Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 D
(e) Length of stay in Baltimore (yrs., mos., or days) one Week

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. County
(c) City or town Norfolk
(d) Street No. 608 Brambelton Ave. (Location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Mary Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Seperated

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-2-1906

8. AGE: Years	Months	Days	If less than one day
38	2	17	27 hr. min.

9. Birthplace Norfolk Va. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Alfred Weeks
13. Birthplace N. C.

MOTHER
14. Maiden Name Lettie Collins
15. Birthplace N. C.

16 (a) Informant Arnette Beaman
(b) Address 5 W. York st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151 MAR 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1944, at 4 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infant of
myocardium

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 30, 1944.

G 15701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G 15701
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Argyle ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 7
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Argyle ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie A Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-1889

8. AGE: Years	Months	Days	If less than one day
54	10	23	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Charles Jones
13. Birthplace N. C.

MOTHER
14. Maiden Name Martha Roundtree
15. Birthplace N. C.

16 (a) Informant Annie B Ellis
(b) Address 1214 Argyle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) MAR 31 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1944 to Mar 28 1944 and that I last saw her alive on Mar 28 1944.

Immediate cause of death
Diabetic Coma
Due to Diabetes
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Goldsborough M. D.
Address 5034 Reisterstown Rd Date signed 3-30-44

G 15702

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46a

G 15702
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Garrison Blvd.
(c) Hospital or institution:

15-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOIS HELEN KILLION

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1885

8. AGE: Years	Months	Days	If less than one day
58	9	16	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Shipley
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Annie R. Pitt
15. Birthplace Howard Co., Md.

16 (a) Informant Mr. John L. Killion
(b) Address 2212 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by local registrar) (b) Registered

MAR 31 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1944, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1944 to Mar 29 1944, and that I last saw her alive on Mar 29 1944.

Immediate cause of death: Carcinoma of esophagus — Duration: about 2 yrs

Due to

Due to

Other Conditions: Carcinoma of esophagus (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

about 2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stella S Hebbert M. D.
Address 2220 Garrison Blvd Date signed Mar 30/44

G 15703

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15703

51B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 Chatham Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Chatham Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter E. Burnham

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marcia G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1866

8. AGE: Years	Months	Days	If less than one day
77	4	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Builder (retired)
11. Industry or business Balto. Dept. Education

FATHER
12. Name George Burnham
13. Birthplace Md.

MOTHER
14. Maiden Name Angeline DeVos
15. Birthplace Md.

16 (a) Informant Mrs. Marcia G. Burnham
(b) Address 3902 Chatham Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date rec'd by Registrar) APR 1 1944 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to March 28 1944
and that I last saw him alive on March 28 1944.

Immediate cause of death	Duration
(1) Carcinoma of Prostate	6 mos?
Due to (2) Generalized Edema	4 mos
Due to Cachexia and Exhaustion	
Other Conditions A-Bronchopneumonia	yes?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. D. Ensor M. D.
Address 7201 York Rd. Balto 12 Date signed 3-29-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15704

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 15704 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 Somerworth Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Somerworth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie H. Murphy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1867

8. AGE: Years 76 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Pikesville, Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

PARENTS

12. Name Michael Murphy
13. Birthplace Ireland

MOTHER

14. Maiden Name Sarah Donovan
15. Birthplace Ireland

16 (a) Informant Minnie H. Murphy
(b) Address 1908 Somerworth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/ 1/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Mt. Olivet

18 (a) Funeral director Edward Foulspe
(b) Address 2359 Wash Blvd

19 (a) MAR 31 1944 (Date rec'd by registrar) (b) Hunting for Whitehead, D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1944, at 12:30 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed

For Dr H.B. McNally by Howard J. Whitehead, M.D.

VS 151

G 15705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 15705 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Holbrook Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Holbrook Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry J. Mc Cubbin (Joseph H. Mc Cubbin)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife: Mary Lauer

6 (c) If alive, give age: Deceased

7. Birth date of deceased (mo., day, yr.) Feb. 13th, 1874

8. AGE: Years 70 | Months 1 | Days 16 | If less than one day: ####### hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Brass Moulder

11. Industry or business

FATHER
12. Name Thomas Mc Cubbin
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Agnes Wager
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Emma Griffin
(b) Address 1601 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave. Balto: County

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Date received by Registrar MAR 31 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29th 1944, at 11 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1944 to Mar. 29 1944, and that I last saw [illegible] alive on Mar. 29 1944.

Immediate cause of death: Malignant tumor of neck, origin undetermined

Duration: 3 mos.

Due to:

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kreamer M. D.

Address 402 E. Lanvale St. Date signed 3-30-44.

15706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15706
Registered No.

166

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Penn Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years 27 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John H. Cook
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sally Washington
15. Birthplace Baltimore Md

16 (a) Informant Sally Cook
(b) Address Patapsco Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West port

18 (a) Funeral director Wm Brooks
(b) Address 1423 N Carey st

19 MAR 31 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1944, at 1A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of abdomen.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-26-44 at 8:50 P. M.
(b) Where did injury occur? TAVERN-913 Penn Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No
(d) Means of injury Shot with revolver during altercation

23. Signature [illegible] M.D.
Medical Examiner.
Date signed March 28, 1944.

VS 161

G 15707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15707
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A

(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Haaken CHRISTIAN Berg

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	217-14-2114	M	W	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 13 1881

8. AGE: Years	Months	Days	If less than one day
63	1	16	hr. min.

9. Birthplace BERGEN NORWAY (Town, county, and state)
10. Usual Occupation MARINE ENGINEER
11. Industry or business MERCHANT MARINE

FATHER
12. Name WALDEMAR BERG
13. Birthplace NORWAY

MOTHER
14. Maiden Name ALOTTA M. RUND
15. Birthplace NORWAY

16 (a) Informant W. BERG (BROTHER)
(b) Address 831 S. BOND ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 1/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) APR 1 - 1944 Huntington Williams, M.D.
Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1944, at 8 15 P M

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic Myocardial Degeneration

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 30 1944

G 15708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15708 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6307 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6307 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Kellogg Lindsay

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Regina Coster
COSTER 6 (If alive, give age) years

7. Birth date of deceased (mo., day, yr.) 8/3/1904

8. AGE: Years 39 | Months 5 | Days 12 | If less than one day: hr. 7 min.

9. Birthplace Chicago Ill (Town, county, and state)

10. Usual Occupation Clerk, U. S. Treasury

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Regina Lindsay
(b) Address 6307 Harford Rd

17 (a) Burial, cremation, or removal (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem Greenmount
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5508 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 to 1944
and that I last saw him alive on March 30, 1944

Immediate cause of death — Duration

Due to Coronary thrombosis 6 hrs.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold A. Scott M.D.
Address 8100 Harford Rd Date signed 3/31/44

447813

G 15709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

80a

G 15709

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Bradenton (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 30th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver M. Shaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Ella C. Shaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-71

8. AGE: Years 73 | Months 4 | Days 27 | If less than one day: hr min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Construction Work

11. Industry or business

FATHER
12. Name Andrew J Shaw
13. Birthplace Pa

MOTHER
14. Maiden Name Nancy Caroline Acke
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) B (Burial, cremation, or removal) (b) Date thereof 4-3-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Miami, Florida

18 (a) Funeral director James J. McCully
(b) Address 130 E. Flagler

19 (a) (Signature of local registrar) (b) [illegible] Registrar

MAR 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1944 at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16 1944 to Mar. 29 1944 and that I last saw deceased alive on Mar 29 1944

Immediate cause of death Cerebellar abscess — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/29/44

Major findings of operation: Cerebellar abscess

of autopsy: Intracranial drag. 3/30/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. W. Saunders M. D.

Address Johns Hopkins Hospital Signed 3/30/44

G 15710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

G 15710

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Fox Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Stewart

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 1 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Howard Stewart
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Eoulda Elliott
15. Birthplace: Baltimore

16 (a) Informant: Howard Stewart
(b) Address: 2812 Fox St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 31 44 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location: A 2 C

18 (a) Funeral director: Rayner Sanders
(b) Address: 1412 E. Preston St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29- 1944, at 7 30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
After Perforation Operation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulder M.D.
Medical Examiner.
Date signed 3-29-44

G 15711 ✓ G 15711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 198

Registered No. ____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 - Forrest St
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 17
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ____
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 - Pasca St. (Rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ____

3 (a) FULL NAME Martin Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife ____
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1924 ? ?

8. AGE: Years	Months	Days	If less than one day
20	?	?	hr. ____ min. ____

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Martin Smith
13. Birthplace Delaware

MOTHER
14. Maiden Name Edith Russ
15. Birthplace Delaware

16 (a) Informant Martin Smith Sr.
(b) Address Sinai Park. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Chas. Alexander
(b) Address 927 N. Mount St.

19 (a) ____ (b) Huntington Hill
(Date received by local registrar) MAR 31 1944 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1944 at 12:14 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1944 to March 31 1944, and that I last saw him alive on March 31 1944.

Immediate cause of death: Dislocation of 5th Cervical vertebra
Due to: Execution by hanging
Due to ____
Other Conditions ____
(Include pregnancy within 3 months of death)
Date of operation ____
Major findings of operations: ____
of autopsy: ____

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury ____

23. Signature C. F. Karns, M. D.
Address Md Pen. Hosp. Date signed 3-31-44

G 15712 ✓ G 15712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3515 Spaulding Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 Spaulding Ave.,
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Bond Harris, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catharine Harris
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 13, 1865

8. AGE: Years	Months	Days	If less than one day
79	11	18	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Lawyers Office

FATHER
12. Name Mathias Harris
13. Birthplace Md.

MOTHER
14. Maiden Name Sherwood,
15. Birthplace Md.

16 (a) Informant Mrs. Irene Gerndt,
(b) Address 3515 Spaulding Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Hampden
Location

18 (a) Funeral director Herman Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) Date rec'd by Registrar MAR 31 1944 (b) Registrar Walter Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1944 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 23 1944 to Mar 31 1944 and that I last saw h alive on Mar 31 1944

Immediate cause of death Angina Pectoris — Duration 3/23/44
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen S. Bubert
Address 4603 Park Heights Ave Date signed 3/31/44 M. D.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15713 KATER HALLOWAY ✓ G 15713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5227 N. Dallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5227 N. Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kater Holloway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	col	

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Elijah Holloway Sr

13. Birthplace Va

MOTHER 14. Maiden Name Martha Wilkerson

15. Birthplace Va

16 (a) Informant Elijah Holloway Jr

(b) Address Smithfield Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)

(c) Cemetery or crematory Evergreen Cemetery

Location Smithfield Va

18 (a) Funeral director Robert E. Williams

(b) Address 1515 Mollison Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

vs MAR 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1943 to March 30 1944. and that I last saw h alive on 3-30 1944.

Immediate cause of death	Duration
Cardio-nephritis	
Due to:	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Parker M.D.

Address 5 E Monument Date signed 3/31/44

15714 ASKINS ✓ G 15714

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 132

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2429 Druid Hill Ave St., 13 Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 53 yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... da.

2. FULL NAME Vilena Askins 13

If U. S. Veteran specify WAR .....

(a) Residence: No. 2429 Druid Hill Ave St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	C	Single

8a. If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6. DATE OF BIRTH (month, day, year) Feb 11, 1891

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	1	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Md.

FATHER

13. NAME Charles Askins

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Annie Pierce

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Annie Anthony (sister)
(Address) 2429 Druid Hill Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Auburn Date 4-1- 1944

19. UNDERTAKER George G. Kelson
(Address) 1803 Presstman St

20. FILED MAR 31 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) ..... 19 .....

22. I HEREBY CERTIFY, That I attended deceased from 3-18-44, 19 ..... to 3-24-44, 19 .....

I last saw her alive on 3-29-44, 19 ..... Death is said to have occurred on the date stated above, at 4:20 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac failure -	

Other contributory causes of importance:
acute Myocarditis
nephritis

Was an operation performed? No Date of .....

For what disease or injury? —

Name of operation — Date of .....

What test confirmed diagnosis Clinical Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Howard Y. Harrison M. D.

(Address) 2346 Eutaw Pl

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

v o 3

G 15715 ✓ G 15715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 N. Charles St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 N. Charles St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country .....

3 (a) FULL NAME Blanche Rodney Crowther Hungerford Latimer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Widowed
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 21, 1885

8. AGE: Years	Months	Days	If less than one day
59	2	10	hr ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Robert R. Hungerford
13. Birthplace Md.

MOTHER
14. Maiden Name Blanche Alice Crowther
15. Birthplace New York State

16 (a) Informant Blanche A. H. Latimer
(b) Address 2100 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery ~~crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAR 31 1944 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1944, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Decmbr 1943 to 3/31 1944, and that I last saw h[illegible] alive on 3/28 1944.

Immediate cause of death: Hypostatic Lobar Pneumonia

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Zach. A. Morgan, M.D.
Address 6 East Read St. Date signed 3/31/44

G 15716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92 D

G 15716
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1421 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcella Todd Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: siggle

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1876

8. AGE: Years 67 | Months 10 | Days 8 | If less than one day: hr min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Benj. W. Jenkins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Frances Hazelhurst
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Fannie H. Riley
(b) Address 1421 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cemy.
Location [redacted]. Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1943 to March 30 1944, and that I last saw her alive on March 29 1944

Immediate cause of death: Myocardial Insufficiency — Duration: Days 2 Hrs

Due to: Arteriosclerosis — 3 yrs

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Billups M D
Address 2224 W. North Ave. Date signed

PHYSICIAN
Underline the cause to which death should be charged statistically.

G 15717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G 15717

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Lucas Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Maryland~~ (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 830 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Czechoslovakia

3 (a) FULL NAME Josephine Barock ~~Baroch~~

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Joseph Barock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1885

8. AGE: Years	Months	Days	If less than one day
59	-	11	hr. min

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Barbara Barock (daughter)
(b) Address 830 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date received by registrar) APR 3 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27, 1944, to March 30, 1944, and that I last saw h alive on March 30, 1944.

Immediate cause of death Cardiac decompensation — Duration Several days

Due to

Due to

Other Conditions Acute Adenocystitis — Several days

(Include pregnancy within 3 months of death)

Date of operation 3/28/44

Major findings of operation: chronic inflammation and dilatation, mid-bile, & gall bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dean Arnold M. D.

Address University Hospital Date signed 3/30/44

G 15718 ✓ G 15718

JL - 87114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Port St/ (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Pohl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1900

8. AGE: Years	Months	Days	If less than one day
44	0	4	hr min.

9. Birthplace Czecho. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis
13. Birthplace Europe ?

MOTHER
14. Maiden Name Frances Svehla
15. Birthplace Europe

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery or [redacted] Holy Redeemer
Location Baltimore, Maryland.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) [redacted] (b) Thos. Williams, M.D. (Date received by registrar) Registrar

AR 33 1944 8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-28- 1944 at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24- 1944 to 3-28- 1944 and that I last saw him alive on 3-28- 1944.

Immediate cause of death: Pulmonary Tbc. — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Shlick
Address 4940 Eastern Ave Date signed 3-28-44 M.D.

451086 G 15719 ✓ G 15719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 92a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State VA (b) County
(c) City or town VICTORIA (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Needham S. Turnbull

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: MARY R.
6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 6-13-86

8. AGE: Years: 57 | Months: 9 | Days: 18 | If less than one day: hr. min.

9. Birthplace: VA (Town, county, and state)

10. Usual Occupation: Judge

11. Industry or business

FATHER
12. Name: Needham S. Turnbull
13. Birthplace: VA

MOTHER
14. Maiden Name: Helen Lewis
15. Birthplace: VA

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 3/31/44 (month) (day) (year)
(c) Cemetery or crematory: Victoria
Location: Victoria

18 (a) Funeral director: Wilhorn Lockard
(b) Address: 2124 Pont St

19 (a) APR 3 1944 (Date rec'd by registrar) Hunter Williams M.D. (Signature of registrar)
(b) 8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAR 31 1944, at 2:33 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 16 1944, to MAR 31 1944, and that I last saw him alive on MAR 31 1944.

Immediate cause of death: Cardiac failure — Duration: 15 min

Due to: Aortic insufficiency

Due to: Subacute Bact Endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm. A. Spaed III M. D.
Address: Johns Hopkins Hosp. Date signed: 3-31-44

G 15720 ✓ G 15720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 Gorman Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V 0
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 Gorman Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Rebecca Amanda Carney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William L. Carney
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12-1857

8. AGE: Years	Months	Days	If less than one day: hr.	min.
86	8	18		

9. Birthplace Greencastle Pennsylvania (Town, county, and state)
10. Usual Occupation Retired housewife
11. Industry or business

FATHER
12. Name George Mathias
13. Birthplace Germany

MOTHER
14. Maiden Name Mary M. Powell
15. Birthplace Germany

16 (a) Informant Stella E. Lerch
(b) Address 36 Gorman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3-1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Greencastle, Penn.

18 (a) Funeral director George F. Schwab
(b) Address 2101 Frederick Ave.

19 (a) 4-3-1944 (Date rec'd by registrar) (b) [illegible] Baltimore MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944. 7:56 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1941, to Mar 30 1944 and that I last saw h[illegible] alive on Mar 29 1944.

Immediate cause of death
Chr. Myocarditis
Due to .....
Due to Chr. Interstitial Nephritis
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1935
9 days

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul J. Brown M. D.
Address 1663 W. North Ave. Date signed 3/30/44

VS 3

G 15721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15721 Registered No. 170a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Co-Randallstown (If outside city or town limits, write RURAL and give town)
(d) Street No. Hirans Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter H. Ruppert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) May 8, 1924 8-5-1924

8. AGE: Years	Months	Days	If less than one day
19 20	10	28	hr. min.

9. Birthplace Randallstown, Md (Town, county, and State)

10. Usual Occupation Automobile mechanic

11. Industry or business

FATHER
12. Name John W. Ruppert
13. Birthplace Randallstown, Md

MOTHER
14. Maiden Name Hannah Homberg
15. Birthplace Baltimore Md

16 (a) Informant Mr. John H. Ruppert
(b) Address Hirans Rd. Randallstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 4510 Liberty Heights Ave.

19 (a) MAR 21 1944 (Date received by registrar) (b) Baltimore, Maryland Registrar

8

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1944, at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-30-44 at 7:15 P.M.
(b) Where did injury occur? Md. Main Crossing Pikesville, W. Md. R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Train and auto collision.

23. Signature H. L. Wollamaker M.D.
Medical Examiner.
Date signed March 31, 1944.

G 15722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 15722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 Linden Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Everett Edmonds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 4-3-44.
(c) Cemetery or crematory Charleston
Location Charleston W Va

18 (a) Funeral director Lee Oder
(b) Address 4644 York Rd.

19 (a) (Date rec'd by Registrar) APR 1 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1944, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/31/44

VS 151

G 15723

JO 205419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G 15723 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 15 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1948 W. Lafayette Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine (Shipley) Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-5132

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leonard Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1908

8. AGE: Years 36 | Months 2 | Days 30 | If less than one day hr min.

9. Birthplace W. Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Hess (d)
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary Gorden (d)
15. Birthplace W. Va.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-44 (month) (day) (year)
(c) Cemetery or crematory Tuscarora Cem
Location Martinsburg W. Va.

18 (a) Funeral director [illegible]
(b) Address Edmondson Ave., Md.

19 (a) (b) Hunting[illegible] Registrar
(Date received by registrar) APR 1 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1944, at 6:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/44 19 to 3/31/44 19, and that I last saw her alive on 3/31/44 19

Immediate cause of death: Carcinoma of cervix c metastasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl B. Kinney M. D.
Address B.C.H. Date signed 3/31/44

15724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

G 15724 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County R. St.
(c) City or town 1404 N. Bond St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH JAMES DERNEC

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 215-03-8341

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E. Derneo
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) March 19, 1905

8. AGE: Years 39 | Months ---- | Days 10 | If less than one day: hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Ship fitter

11. Industry or business Bethlehem-Fairfield

FATHER
12. Name Charles Dernec
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sophia Roble
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Margaret E. Derneo
(b) Address 1504 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (Month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] to Williamsport (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1944 at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1944, to 3/29 1944, and that I last saw h[illegible] alive on 3/29 1944.

Immediate cause of death Embolism

Due to Acute Bacterial Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: March 29, 1944

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Sellers

Address 1400 N. Caroline Date signed 3/29/44 M. D.

15725 G 15725

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1929

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1137 Patapsco Ave
(c) Hospital or institution:
South Baltimore General Hosp 25 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME ELLA LEONA BROOK

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry J. Brook

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1879

8. AGE: Years 64 | Months 4 | Days 8 | If less than one day: ..... hr. ..... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER
12. Name Steven Lynch
13. Birthplace Balto.

MOTHER
14. Maiden Name Ella Smith
15. Birthplace Balto.

16 (a) Informant Harry J. Brook
(b) Address 1137 Patapsco Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944, at 10:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute bacterial endocarditis of aortic valve.

Due to Rupture of Aortic aneurysm.

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury?

23. Signature Robert Lee Fratarcangeli M.D.
Medical Examiner.

Date signed March 30, 1944

15726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C 15726

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution: Crawford Retreat 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Wk.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Parkaw
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME John Thomas Smith

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Beatrice Barton

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Sept-26-1875

8. AGE: Years	Months	Days	If less than one day
68	6	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Watchmaker

11. Industry or business —

FATHER 12. Name Thomas F Smith

13. Birthplace New York

MOTHER 14. Maiden Name Elizabeth J. Barton

15. Birthplace Bally. Md

16 (a) Informant Mrs Beatrice B. Smith (wife)

(b) Address 2012 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Balto. Co. Md.

18 (a) Funeral director Steward Memorial Company

(b) Address 108 W. Mt. Ave.

19 (a) APR 1 - 1944 (b) (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1944, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 15th 1944 to MARCH 29th 1944, and that I last saw him alive on MARCH 27 1944.

	Duration
Immediate cause of death Hemiplegia	1 week
Due to Uremia & Cancer	10 Months
Due to Unknown	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Conrad Bode M. D.

Address 1900 Maryland Ave Date signed 3-30-1944

G 15727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH ✓ 49a

G 15727

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Cambridge Apts St., 12 Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Grace Beatam Rose

If U. S. Veteran specify WAR .....

(a) Residence: No Cambridge Arms apts St., 12 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

3a. If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of John C Rose

6. DATE OF BIRTH (month, day, year) April 22 1865

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	11	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) Feb 1943

11. Total time (years) spent in this occupation Entire life

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME George Beatam

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

MOTHER

15. MAIDEN NAME Matilda Swan

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Mrs Douglas Rose (son)
(Address) Fidelity Trust Co.

18. BURIAL, ~~CREMATION, OR REMOVAL~~
Place London Park Date April 3/ 1944

19. UNDERTAKER Stewart Mowbray Co.
(Address) 10 W Mount Ave.

20. FILED APR 11 1944
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 31, 1944

22. I HEREBY CERTIFY, That I attended deceased from January, 1944 to March 31, 1944 last saw her alive on March 31, 1944. Death is said to have occurred on the date stated above, at 4:20 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of ovary	1943
Other contributory causes of importance: Metastases to liver	Feb 1944

Was an operation performed? no Date of .....

For what disease or injury? —

Name of operation — Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in **industry**, in **home**, or in **public** place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify .....

(Signed) Francis W. Black, M. D.

(Address) 715 Park Ave

OCCUPATION is very important. See instructions on back of certificate.

vs 3

15728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1937 Registered No. G 15728

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 E. 28th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 80

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 E. 28th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella E Christopher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George W. Christopher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1855.

8. AGE: Years	Months	Days	If less than one day
88	7	29	hr. min

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Mason
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Elizabeth Christopher
(b) Address 323 E. 28th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director William Cook, Inc.
(b) 1217 St. Paul Street

19 (a) APR 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1944, at 4 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D.
Medical Examiner.
Date signed March 31, 1944.

15729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 55 B

G 15729
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3231 St. Paul St.
(c) Hospital or institution:
12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 w 4 & Ko

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Kannapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Clara E. Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
Female	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 6th 1919

8. AGE: Years	Months	Days	If less than one day
24	10	26	hr. min.

9. Birthplace Bedford Co. Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Lent C. Price

13. Birthplace Va.

MOTHER 14. Maiden Name Ruth Niff

15. Birthplace Bedford Va.

16 (a) Informant Ruth Price Martin

(b) Address Kannapolis N.C.

17 (a) Removal (b) Date thereof 4/1/44
(~~Burial, cremation, or~~ removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Kannapolis
Location North Carolina

18 (a) Funeral director William Cook Inc

Address 217 St. Paul St.

APR 1 1944
(Date rec'd by registrar)

19 (a) (b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31st 1944, at 4 45 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1944 to MAR 30 1944 and that I last saw her alive on March 30 1944.

Immediate cause of death Ewing's Sarcoma with metastasis — Duration 5 yrs

Due to

Due to Empyema of Chest (Lt)

Other Conditions Myocarditis (infective)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. V. Harold M. D.

Address 4706 Harford Road Date signed 3/31/44

G 15730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 15730

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5263 St. Charles Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1/8

(e) Length of stay in Baltimore (yrs., mos., or days) 75 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 5263 St. Charles Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida A. Whaley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ James E. Whaley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23rd 1863

8. AGE: Years	Months	Days	If less than one day
80	7	8	hr. min.

9. Birthplace Alexandria Va. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Mathew Miller

13. Birthplace Unknown

MOTHER 14. Maiden Name Rebecca

15. Birthplace

16 (a) Informant Chas. N. Whaley

(b) Address 2801 Westfield Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4, 3, 44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Oak Lawn

Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. ~~Huntington~~ Williams, Md.

19 APR 1 - 1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31st 1944 at 2 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16th 1939 to 3/31 1944. and that I last saw her alive on 3/31 1944.

Immediate cause of death Chronic Myocarditis — Duration 1 yr

Due to Coronary Sclerosis — 2 yrs.

Due to Art. Sclerosis — 5 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James A. Mullen M.D.

Address Pikesville, Md. Date signed 3/31/44

C 15731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C 15731

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 747 E. Melville Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days) 54 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 747 E. Melville Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ludwika Louisa Dmochowska

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10 0415

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Alexander Dmochowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24th 1887

8. AGE: Years 54 | Months 11 | Days 6 | If less than one day: hr. min

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Modern Laboring Co

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Henrietta Dmochowska
(b) Address 747 E. Melville Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location

18 (a) Funeral director William Cook - Inc
(b) Address 1217 St. Paul St.

APR 1 - 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D. (Signature)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1944, at 12:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Mar 1944, to 30 Mar 1944, and that I last saw her alive on 30 Mar 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 Hrs.

Due to: Arteriosclerosis — 3 yrs.

Due to:

Other Conditions: 0

(Include pregnancy within 3 months of death)

Date of operation: 0

Major findings of operation: 0

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 0
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Hooper M. D.
Address 3534 Ellerslie Ave Date signed 30/3/44

Spec.—8-24-14—M. & T.—2000 Bks.

15732 HEALTH DEPARTMENT—CITY OF BALTIMORE G 15732

CERTIFICATE OF DEATH. 193D

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Orkney Road ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

2-FULL NAME Mary Eva Savin

(Residence in Baltimore: No. 603 Orkney Road 27-8 St.; 31 yrs., mos. da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. June 18, 1880 (Month) (Day) (Year)

7-AGE. 63 yrs. 10 mos. 12 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Charles Ehmann

11-BIRTHPLACE OF FATHER (State or Country). Washington D.C.

12-MAIDEN NAME OF MOTHER Ida Dillihunt

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew A. Savin

(Address) 603 Orkney Lane.

15 APR 1 - 1944 Filed....., 191. Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 30, 1944. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1944, to Mar 30 1944, that I saw her alive on Mar 30 1944, and that death occurred, on the date stated above, at 9.45 p m.

The CAUSE OF DEATH* was as follows:

Acute Cond. in Endocarditis

Myocarditis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Hypertension

(Duration) 6 yrs. mos. da.

(Signed) R. D. Dellenbaugh M. D.

March 30, 1944 (Address) Towson Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Gorms Presbyterian

DATE OF BURIAL. 4/3 1944

20-UNDERTAKER Wm Cook Inc

ADDRESS 1217 St Paul

15738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G 15733
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Ford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Col.	Married

6 (b) Name of husband or wife Pauline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day hr.	min.
83				

9. Birthplace California (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER 12. Name Nelson Ford
13. Birthplace California

MOTHER 14. Maiden Name Mary Fitzgerald
15. Birthplace

16 (a) Informant Pauline Ford
(b) Address 2008 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lew. H. Holland
(b) Address 1631 Druid Hill Ave

19 APR 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1944, at 1 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 27, 1944, to March 29 1944, and that I last saw h alive on March 29 1944.

Immediate cause of death	Duration
Bilateral Bronchopneumonia	8 days
Due to Uremia Eclampsia	10 hrs.
Due to Cerebral Edema	14 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation March 8, 1944
Major findings of operations Cystoscopic examination
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert L. Riggins M. D.
Address 2025 Madison Ave Date signed 3/29/44

15734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 15734

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md.
(c) Hospital or institution:
716 E. Preston St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH C. BRANDT

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Albert H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1863

8. AGE: Years	Months	Days	If less than one day
80	5	1	hr. min

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Butzler
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Jungtow
15. Birthplace Germany

16 (a) Informant Mr. Charles B. Brandt
(b) Address 716 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 1 - 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1944 to 3/29 1944 and that I last saw h[illegible] alive on 3/28 1944

Immediate cause of death
Carcinoma L Breast. Removal,
Due to Metastasis to Lung
Due to
Other Conditions arteriosclerosis

Duration 6 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which place)
(e) Means of injury

23. Signature [signature] M. D.
Address 20 W. 20th St. Date signed 3/30/44

G 15735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G 15735

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 N. Augusta ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 & 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 N. Augusta ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE P. WADE

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race white

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James F. Wade

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1864

8. AGE: Years 79 | Months 6 | Days 24 | If less than one day hr min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name James P. O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Power
15. Birthplace Ireland

16 (a) Informant JAMES WADE
(b) Address 911 N. Augusta avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Edward J. Engel Son
(b) Address 118 N. Mt. Royal Ave

19 (a) (Date rec'd by registrar) APR 1 - 1944 (b) Registrar

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 44, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1943 March 30 1944
and that I last saw h[illegible] alive on 3/30/44 19

Immediate cause of death: Acute Myocarditis — Duration: 2 days

Due to: Hypertension

Due to: Arteriosclerosis

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Thos. Foster M.D.

Address 401 Edmondson Date signed 3/31/44

G 15736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 15736
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Silver Springs
(If outside city or town limits, write RURAL and give town)
(d) Street No. Xaverian College
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brother Thomas Fitzpatrick - C.F.X.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1876

8. AGE: Years	Months	Days	If less than one day
67	3	6	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation ~~Patient~~ Brother

11. Industry or business

FATHER 12. Name Thomas Fitzpatrick

13. Birthplace Virginia

MOTHER 14. Maiden Name Mary Langly

15. Birthplace Virginia

16 (a) Informant REV. BRO. VICTORINN. C.F.X. IRVINGTON

(b) Address MT. ST. JOSEPH'S COLLEGE

17 (a) BURIAL (b) Date thereof 4/3/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL

Location

18 (a) Funeral director Chas. J. Eugene Sontag

(b) Address 118 N. Mt. Royal Ave.

19 (a) (b)
(Filed by registrar) Registrar

APR 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28/44 19 to 3/31/44 19, and that I last saw h alive on 3/31 19 44

Immediate cause of death	Duration
Peritonitis	
Due to Empyema of Gall Bladder.	
Due to	
Other Conditions Diabetes, psoriasis; Chronic myocarditis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryson M.D.

Address St. Agnes Hosp. Date signed 3/31/44

G 15737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

G 15737
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Bradford St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. William Jamison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Henretta C Jamison
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan 14 - 1886

8. AGE: Years	Months	Days	If less than one day
58	2	17	hr. min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Oriole Wood Products Co

11. Industry or business

FATHER
12. Name Robt M Jamison
13. Birthplace Baltimore

MOTHER
14. Maiden Name Frances Valiant
15. Birthplace Baltimore

16 (a) Informant Mrs Thos Andrews.
(b) Address 143 E Mount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 3-1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2007 Eutaw Pl. Huntington Williams, Jr.

APR 1 - 1944 (Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1944 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1944. to 3/31 1944. and that I last saw h[illegible] alive on 3/31 1944.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Congestive Heart failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Dr. H.E. Wallace M. D.
Address 1400 N. Carolina Date signed 3/31/44.

VS 150

C 15738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 38E

Registered No. C 15738

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 N. Gilmor St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/94

8. AGE: Years	Months	Days	If less than one day
1 2	8	24	hr. min.

9. Birthplace Snow Hill N. C. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Raymond Barnes
13. Birthplace Snow Hill, N.C.

MOTHER 14. Maiden Name Louvella Barnes
15. Birthplace Snow Hill, N.C.

16 (a) Informant Raymond Barnes
(b) Address 307 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Wm H R Walker
(b) Address 1911 Schroeder Hunting or Pulaski, Md

APR 1 - 1944

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944, at 9:45 A M

21. I certify that I took charge of the remains described above, held an Inquest & Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to Chicken Pox

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 27 1944

VS 151

G 15739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

512

G 15739
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 E. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 E. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Nathan F. Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Clara S. Carter
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1867

8. AGE: Years	Months	Days	If less than one day
76 67	4	20	hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Franklin B. Carter
13. Birthplace Pa.

MOTHER
14. Maiden Name Eve Steltz
15. Birthplace Pa.

16 (a) Informant Mrs Clara S. Carter
(b) Address 745 E. ColdSpring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Fountain Green, Harford Co.

18 (a) Funeral director Frederick J. Cox
(Address) 1 Lombard St.

19 (a) APR 1 1944 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1944, at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1943, to March 30 1944, and that I last saw h[illegible] alive on MAR 30 1944

Immediate cause of death Terminal Pneumonia — Duration

Due to Carcinoma of Prostate

Due to

Other Conditions Arteriosclerosis Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 300 1 Eastern Ave Date signed April 1-44

5740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 6-16740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 Dumbarton Ave
(c) Hospital or institution:
Union Memorial Hosp. 9 ward
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 Dumbarton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary E. Le Compte

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 2, 1861

8. AGE: Years	Months	Days	If less than one day
82	3	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Rock (O)
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Marshall
15. Birthplace Maryland

16 (a) Informant Mrs. Cora E. Hunter
(b) Address Same

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-3-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Fredericks & Son
(b) Address 1210 W. Lombard St.

19 APR 1 - 1944 (Date rec'd by registrar) Hunter Pittman M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1944, at 6:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1944, to 3-30 1944, and that I last saw her alive on 3-30 1944.

Immediate cause of death Cerebro-Respiratory Failure — Duration

Due to Cerebral Hemorrhage

Due to Arteriosclerosis

Other Conditions Exposure to Gas (Natural) at Home.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Humphreys Jr. M. D.
Address 337 E. University Pkwy. Date signed 3/30/44

G 15741

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15741 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 S. Durham St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days life

2. USUAL RESIDENCE OF DECEASED
a State Md b County
c City or town (If outside corporate limits write RURAL and give town)
d Street No. 108 S. Durham St (If rural give location)
e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mary Jefferies

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	divorced

6 (b) Name of husband or wife — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1 - 1892

8. AGE: Years 51 | Months 9 | Days 24 | If less than one day hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Server

11. Industry or business

FATHER 12. Name C. Jackson
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Elizabeth Lulay
(b) Address #218 Grace Ct. Catonsville Md

17 (a) Burial, cremation, or removal (b) Date thereof 4/3/44 (month, day, year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. L. Hyatt's Sons
(b) Address Lombard and Fulton Sts.

APR 1 - 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944 at 10 53 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from ~~Nov~~ March 30 1937 to March 30 1944 and that I last saw h~~e~~r alive on Mar 30 1944

Immediate cause of death
General Arteriosclerosis
Chronic Myocarditis

Duration: 7 yrs, 7 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
a Accident, suicide, or homicide
b Date of occurrence at M
c Where did injury occur? (City or town) (County) (State)
d Did injury occur about home, on farm, industrial place, in public place? While at work?
e Means of injury

23. Signature Milton L. Solomon M.D.
Address 129 S. Bway Date signed 4/3/44

G 15742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5a

G 15742
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 St. Paul St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 St. Paul St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Willie Dryden Gaither

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Charles P. Gaither
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. March 20, 1870

8. AGE: Years	Months	Days	If less than one day
74	0	10	hr min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William B. Dryden
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Hanway
15. Birthplace Baltimore

16 (a) Informant Grace G. Tucker
(b) Address 2101 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1300 Eutaw Place

19 a) APR 1 - 1944 Registrar of the Millennium

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1944 to Mar. 30 1944, and that I last saw h[illegible] alive on Mar. 30 1944.

	Duration
Immediate cause of death: Acute Pyelo-Nephritis	4 days
Due to Ovarian Cyst.	8 years
Due to Hypertension (Renal)	6 years
Other Conditions General Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation No
Major findings of operation: Uterus & Ovaries Plaques in pelvic area
Findings of autopsy Acute Pyelo Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Gibson Porter M D
Address 4828 Roland Ave. Date signed

G 15743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15743 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1606 Bolton St.

(c) Hospital or institution: none

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs. mos., or days 43 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State [illegible] (b) County [illegible]

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1606 Bolton St.

(If rural, give location)

(e) Citizen of foreign country? No Yes or No?

If yes, name country

3 (a) FULL NAME Eleanor V. Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: George E. Ward

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. April 4, 1865

8. AGE: Years 78 | Months 11 | Days 26 | If less than one day: hr min

9. Birthplace: Delaware (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER

12. Name: Thomas W. Vincent

13. Birthplace: Del.

MOTHER

14. Maiden Name: Hester Ann Moore

15. Birthplace: Del.

16 (a) Informant: Emma E. Buckey

(b) Address: 1606 Bolton St.

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 4/3/44 (month) (day) (year)

(c) Cemetery or crematory: Woodlawn

Location: Woodlawn, Md.

18 (a) Funeral director: John O. Mitchell & Sons, Inc.

(b) Address: 1900 Eutaw Place

19 (a) APR 1 - 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 3/30 1944 and that I last saw h[illegible] alive on 3/29 1944

Immediate cause of death: Coronary thrombosis — Duration: 1 day

Due to: Uremia - Valvular heart and Art. Sclerosis — 1540

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: [signature] M. D.

Address: 1301 Eutaw Place Date signed: 3/31/44

G 15744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15744
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 Brentwood Ave
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
a. State Md b. County
c. City or town Balto Md
(If outside city or town limits, write (R) AI and give town)
d. Street No. 1907 Brentwood Ave
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Emma N Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race W Like
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1855

8. AGE: Years 88 | Months 10 | Days 27 | If less than one day: hr min

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Geo Frank Dickerson
13. Birthplace Md

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs Mary Ruhl
(b) Address 1907 Brentwood Ave

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director Edw Poulson
(b) Address 2869 Wash Blvd
Date received by registrar APR 3 - 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1944 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14 1939 to 3-31 19XX, and that I last saw her alive on 3-31 19XX

Immediate cause of death
Due to Myocardial Degeneration — Duration: 8 yrs
Due to
Other Conditions Myocardial Degeneration — Duration: 4 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify one) While at work?
(e) Means of injury
23. Signature David Miller
Address 5 S Broadway Date signed 4/1/44 (M D)

G 15745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15745 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 S. Rappole St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S Rappolla St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM. F. Herz Wm.

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NONE

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife ANNA HERZ

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 2-1865

8. AGE: Years 79 | Months 0 | Days 29 | If less than one day: hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business R.R. WATCHMAN

FATHER
12. Name FREDERICK HERZ
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant WILLIAM P. HERZ (SON.)
(b) Address 421 EVESHAM AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-3-44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

APR 2-1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 19 44, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Inquest-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive C.V disease c
Myocardial failure

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner
Date signed 3/3-/44

15746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106c

Registered No. 15746

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene

(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED

a State Md b County

c City or town Baltimore (If outside city or town limits, write RAE and give town)

d Street No 217 W Hamilton st (If rural give location)

e Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Ida Morber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race B

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 44 Months Days If less than one day hr min

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER

12. Name Daniel Spruta

13. Birthplace N.C.

MOTHER

14. Maiden Name Mary Read

15. Birthplace N.C.

16 (a) Informant Margaret Jackson

(b) Address 217 W Hamilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A A Co. Md

18 (a) Funeral director Isaiah L Brown

(b) Address 108 W Montgomery St

19 (a) (Date received by registrar) (b) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1944 at 2:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/26 1944, to 3/30 1944, and that I last saw her alive on 3/30 1944

Immediate cause of death as per autopsy asphyxia — **Duration**

Due to Laryngotracheal edema

Due to Laryngo-tracheitis

Other Conditions Rt pneumothorax

(Include pregnancy within 3 months of death)

Date of operation 3/27/44 tracheotomy

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature William D. Lyon M D

Address University Hospital Date signed

G 15747

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15747 Registered No. 136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1049 Asquith St
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1049 Asquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Massenburg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife John
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1911

8. AGE: Years	Months	Days	If less than one day
29	3	4	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Clayton Liggins
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Anthony
15. Birthplace Va.

16 (a) Informant Martha Thomas
(b) Address Edgemere Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1/44 (month) (day) (year)
(c) Cemetery or crematory Smithfield Va
Location

18 (a) Funeral director Chas. Robert A. Elliott & Sons
(b) Address 1129 N. Caroline St.

19 (a) (b)

APR 2 - 1944

VS 150

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1944, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944, to March 29 1944, and that I last saw h[illegible] alive on March 28 1944.

Immediate cause of death Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Runnels M. D.
Address 1422 E. Chase Date signed 3-30-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15748 ✓ Registered No. 22a

G 15748

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James Dickey

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1942

8. AGE: Years	Months	Days	If less than one day
1	3		hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name	George Dickey
FATHER 13. Birthplace	South Carolina
MOTHER 14. Maiden Name	Lavenia Fullard
MOTHER 15. Birthplace	South Carolina

16 (a) Informant Allen Fuller
(b) Address 820 Druid Hill Ave.
17 (a) Burial, cremation, or removal (b) Date thereof 4/5/44 (month, day, year)
(c) Cemetery or crematory [illegible]
(d) Location [illegible]
18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.
19 (a) Date received by registrar 4-6-1944 (b) [illegible] Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1944, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1944, to 3/31 1944, and that I last saw him alive on 3/31 1944.

Immediate cause of death	Duration
Miliary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Rinehart, M.D.
Address University Hospital Date signed 4/6/44

G 15749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G 15749
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State
(b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB TOPAZ

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Dyer

FATHER
12. Name Abraham Topaz
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Leah
15. Birthplace Russia

16 (a) Informant Mr Samuel J Topaz
(b) Address 1507 N Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) APR 2 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1944, at 1:56 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1944 to 4/1 1944, and that I last saw him alive on 4/1 1944.

Immediate cause of death respiratory failure — Duration

Due to

Due to

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 3/29/44

Major findings of operation: appendix, right leg

of autopsy: none

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Schlis
Address Sinai Hospital Date signed 4/1/44

G 15750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15750 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 E Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josef Kadish

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-8692

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1872

8. AGE: Years	Months	Days	If less than one day
72	1		hr min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Tailor

FATHER
12. Name Michael Kadish
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie ?
15. Birthplace Russia

16 (a) Informant Michael Kadish
(b) Address 1530 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem.
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North ave

APR 2 - 1944 (Date rec'd by Registrar) Huntington Williams (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1944, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944, to 4/1 1944, and that I last saw him alive on 4/1 1944.

Immediate cause of death Myocardial failure — Duration

Due to Acute rt. ventricular failure

Due to Hypertensive arterio-sclerotic h. dis.

Other Conditions Myocardial infarct (old) Intraventricular dissecting aneurysm.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Dr. Gerber, Edema, myocardial

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Aronson M. D.
Address Sinai Hosp Date signed 4/1/44

G 15751

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15751 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 Edison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick H. Seitz Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-05-7724

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude Seitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17 - 1903

8. AGE: Years: 40 | Months: 7 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Attendant at gasoline

11. Industry or business: Station

FATHER
12. Name: Conrad Seitz
13. Birthplace: Balto

MOTHER
14. Maiden Name: Minnie —
15. Birthplace: Balto, Md.

16 (a) Informant: Mrs. Gertrude Seitz
(b) Address: 317 Edison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 3 43 (month) (day) (year)
(c) Cemetery or crematory: St. Mathews
Location: Baltimore

18 (a) Funeral director: Philip Hirsh's Sons
Address: 1940 Pennsylvania Ave

APR 2 1944

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944, at 7:45 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions Cor Mitral Endocarditis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham, M. D. M.D.
Medical Examiner.
Date signed March 31, 1944

For R. L. Graham, by Howard J. Mackerle, M.D.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15752

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G 15752 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Ashland Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH CRIVELLO

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Joseph Crivello
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) 30 July 1886

8. AGE: Years	Months	Days	If less than one day hr	min
57	8	1		

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Fruit stall in market
11. Industry or business

FATHER
12. Name Joseph Crivello
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Pistorio
15. Birthplace Italy

16 (a) Informant Wife
(b) Address 2614 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Wendell E Humphreys
(b) Address 1401 N. Broadway

19 (a) (Date rec'd by local registrar) (b) Huntington Williams, M.D. (Registrar)

APR 2 - 1944

VS 460

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 April 19 44 at 2:37 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Mar 1944 to 1 April 1944 and that I last saw him alive on 1 April 1944

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: arteriosclerotic heart disease

Due to:

Other Conditions: Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation: Negative, coroner

Major findings of operation: unknown

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Fell III M. D.
Address Union Memorial Hosp Date signed 4-4-44

G 15753 Muir

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15753 Registered No. 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mattie DeShields Muir

3 (b) If veteran, name war

3 (c) Social Security Account No.

5/31/44

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar-31 1944 at 9: A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1944 to 3/31 1944 and that I last saw h alive on 3/30 1944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Married

6 (b) Name of husband or wife Howard Muir

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1918

8. AGE: Years	Months	Days	If less than one day
25 26	4	7	hr. min.

9. Birthplace Laurel, Del. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Gladys Fuller

(b) Address 26 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) April 3 (day) 1944 (year)

(c) Cemetery or crematory Laurel Del

Location Del

18 (a) Funeral director E. O. Wilson

(b) Address Greenbrier

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

Immediate cause of death Carcinoma of Breast

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Truscheim M. D.

Address 1111 Lee Date signed 4/1/44

G 15754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G 15754

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 644
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CELIA SNYDER

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-7630

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. Age Years	Months	Days	If less than one day hr.	min.
35				

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER: 12. Name Joe Snyder
13. Birthplace Russia

MOTHER: 14. Maiden Name Annie —
15. Birthplace Russia

16 (a) Informant Harry Snyder (Son)
(b) Address 2018 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-44 (month) (day) (year)
(c) Cemetery or crematory Pikesdale
Location Phila Rd. & Franklyn Ave

18 (a) Funeral director Dorsey & Sons Inc
(b) Address 1432 Balto St

19 (a) APR 2 - 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1944, at 9.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 1944 to 3-31 1944, and that I last saw her alive on 3-31 1944.

Immediate cause of death: Respiratory Failure — Duration

Due to: Pulmonary Edema

Due to: Rheumatic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wayne S Arrick
Address Sinai Hosp. Date signed 3-31-44 M. D.

VS 150

G 15755

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15755 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 Edgewood Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Edgewood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Ruseman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Pearl Hetta Ruseman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day hr.	min.
67				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER
12. Name Israel Wm. Ruseman
13. Birthplace Russia
14. Maiden Name Hannah –
15. Birthplace Russia

16 (a) Informant Joseph Ruseman
(b) Address 3805 Harrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad'a & Franklin ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St.

19 (a) – 1944 (Date filed by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1944 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1943 to 3/31 1944 and that I last saw him alive on 3/31 1944

Immediate cause of death
Heart disease
Due to Coronary disease
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marcia Schiedeck M.D.
Address 220 Tenbrook Date signed 4/1/44

VS 150

G 15756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G 15756 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4821 Reistertown Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4821 Reistertown Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Margaret Dean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles Dean

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 5, 1862

8. AGE: Years 81 | Months 4 | Days 26 | If less than one day: hr min

9. Birthplace: Pa. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: Henry Jopp

13. Birthplace: Germany

MOTHER

14. Maiden Name: Margaret Schultz

15. Birthplace: Germany

16 (a) Informant: Mrs. Carrie Dean

(b) Address: 4821 Reistertown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)

(c) Cemetery or crematory

Location: Denton Md.

18 (a) Funeral director: Virgil Moore

(b) Address: Denton Md.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 2 VS 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1944, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1939, to April 1, 1944, and that I last saw her alive on April 1, 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to: Arteriosclerosis, — Duration: many years

Due to: Hypertension. — Duration: 4 years

Other Conditions: Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Theodore H. Monisone M. D.

Address 11 E Chase St Date signed 4/1/44

G 15757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G 15752
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Ellerslie Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Ellerslie Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm Henry Coleman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	W.

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan - 28 - 1873

8. AGE: Years	Months	Days	If less than one day
71	2	2	hr. min.

9. Birthplace Alexandria Va.
(Town, county, and state)

10. Usual Occupation City Inspector
11. Industry or business Balto. City

FATHER
12. Name Unknown Coleman
13. Birthplace " Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Wm J Coleman
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 3. 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Parkville

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 E. Lexington St Baltimore, Md.

19 (a) APR 2 - 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31. 1944, at 1.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 14 1944 to Mar 31 1944, and that I last saw him alive on March 31 1944.

Immediate cause of death Pulmonary Edema — Duration 24 hrs.
Mitral & aortic stenosis — ?
Due to Arterio sclerotic Cardio vascular disease — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony J Thomas M. D.

Address 4000 York Rd Date signed 4/1/44

G 15758

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183

G 15758
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. S.S. Norsjell (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alf. Anderson (ANDERSEN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 17 1903

8. AGE: Years	Months	Days	If less than one day
40	3	9	hr. min.

9. Birthplace Larik, Norway (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business S.S. Norsjell

FATHER
12. Name (Unknown) Anderson
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Norwegian Consulate
(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) ~~Cemetery~~ crematory Green Mount
Location Balto. Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1944, at 4:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work?
(d) Means of injury Found drowned

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 31 1944

G 15759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15759 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 Md. Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City ~~or town~~ Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Md. Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Edgar Irving Whiteside

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Anna Carolyn Whiteside
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22nd ~~1878~~

8. AGE: Years	Months	Days	If less than one day hr.	min
65	8	9		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Postal Supervisor
11. Industry or business U. S. Post Office

FATHER
12. Name William H. Whiteside
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Alice C. Whiteside
(b) Address 2420 Md. Ave

17 (a) Burial (b) Date thereof 4/3/44 (month) (day) (year)
(Burial, ~~cremation, or removal~~)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.
18 (a) Funeral director William Bork Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31st 1944, at 8:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to March 30 1944, and that I last saw ~~alive~~ on March 30 1944.

Immediate cause of death
Acute cardiac failure
Due to Chr. Valvular heart disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
—
8 yrs.

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Welly M. D.
Address 4100 Edmondson Ave Date signed 4/1/44

JO #81209 15760

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 139a

Registered No. C 15760

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Black Magnolia Miley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Shellie Miley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1904

8. AGE: Years 39 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Williams
13. Birthplace South Carolina

MOTHER
14. Maiden Name Roxie ?
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Asheville Location North Carolina

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Stockbridge St Winston-Salem, N.C.

19 (a) (b) Registrar

(Date received by registrar) APR 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1944, at 3:46 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1944 to 3-31 1944 and that I last saw her alive on 3-31 1944

Immediate cause of death
Generalized Peritonitis
Due to Pelvic Inflammatory Disease
Due to

Duration: 5 days ?

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3-31-44
Major findings of operation: Above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B Kabb
Address Baltimore City Hosp Date signed 3-31-44

G 15761

BALTIMORE CITY HEALTH DEPARTMENT

AB-16210

CERTIFICATE OF DEATH

G 15761 / 97

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Yrs-11Mos.-24 days

(e) Length of stay in Baltimore (yrs., mos., or days) 43 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 226 Bowers Court (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME William H. Welling or William H. Wellens

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife ? Susie Welling

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April-20-1858

8. AGE: Years	Months	Days	If less than one day
85	11	8	hr ..... min.

9. Birthplace South Hampton County, Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business .....

FATHER

12. Name Sampson Welling or Wellens

13. Birthplace Va.

MOTHER

14. Maiden Name Tamy ?

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location .....

18 (a) Funeral director Mrs Katie R Williams

(b) Address 3224 N Schroeder St.

19 (a) APR 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1931 to 3/28 1944 and that I last saw h[illegible] alive on 3/28 1944.

Immediate cause of death Pneumonia — Duration 2

Due to Generalized Arteriosclerosis — Duration ?

Due to ( ) — Duration .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Paul Mall

Address B. Md. Date signed 3/28/44 M.D.

G 15762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

G 15762

Registered No. .....

AB-86363

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos-21 days

(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 746 W. Redwood St. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME Daniel Munn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5-1874

8. AGE: Years	Months	Days	If less than one day
69	8	24	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Ruffin Munn (D)

13. Birthplace North Carolina

14. Maiden Name Susan Merritt (D)

15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location .....

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) ..... 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29 1944 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1944 to Mar 29 1944 and that I last saw him alive on Mar 28 1944.

Immediate cause of death: Carcinoma of Rectum & Metastasis — Duration: 7-10 yrs

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operations: .....

.....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Thomas J. Pierpont M. D.

Address Balto City Hosp Date signed Mar 30 1944

G 15763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G 15763 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 1
(e) Length of stay in Baltimore (yrs., mos., or days) 49

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Cordelia

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name John Townsend

13. Birthplace Md

MOTHER 14. Maiden Name Mary

15. Birthplace Md

16 (a) Informant Cordelia Townsend

(b) Address 1602 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St.

19 (a) APR 3 - 1944 (Date rec'd by registrar) (b) Signature for Wm. [illegible]

VB 280

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944. at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1943. to 3-30 1944. and that I last saw h— alive on 3-28 1944.

Immediate cause of death Cerebral Hemmorrhage — Duration

Due to Mitral Insufficiency

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M.D.

Address 1646 E Monument Date signed 3/30/44

G 15764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15764

Registered No. 80a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVE RIBBON BEFORE BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town SCRANTON. (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 FIG 5T (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA GURECKI

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years	Months	Days	If less than one day
13			hr. min.

9. Birthplace PA (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Paul Gurecki
13. Birthplace Poland

MOTHER
14. Maiden Name ANNA Zaywstoski
15. Birthplace Poland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Sacred Heart of Jesus + Mary
Location Minooka, Pa.

18 (a) Funeral director John L. Mitchell & Son, Inc.
(b) Address 19 as Eutaw Place

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

APR 2 1944 No.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944, at 1 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944 to 4/2 1944, and that I last saw h[illegible] alive on 4/2 1944

Immediate cause of death Brain abscess — Duration

Due to Otitis Medias infection from right middle ear

Due to Mastoid

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/2/44

Major findings of operation: Abscess in right temporal lobe of brain

of autopsy None performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Johns Hopkins Hospt Date signed 4/2/44

G 15765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15765 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Hillen St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Hillen St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Reis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day hr.	min.
45				

9. Birthplace Trinidad, West Indies
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Garage

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Tiney Reis
(b) Address 905 Hillen St.

17 (a) Burial (b) Date thereof Apr. 3-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. a. Co., Md

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Fayette St

APR 2 1944 (Date) Huntington Williams, M.D.
(Registrant)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 - 1944 at 8:50 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1944 to March 30 1944 and that I last saw him alive on March 29 1944

Immediate cause of death: Cardiovascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Purnell

Address 1422 E. Chase Date signed 3-30-44

M. D.

G 15766

VL - 87004

G 15766

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

309

Registered No. G 15766

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hume Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sept.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1899

8. AGE: Years	Months	Days	If less than one day
44	5	16/17	hr min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James A. Butler
13. Birthplace Pa.

MOTHER
14. Maiden Name Fannie Waters
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Thomas
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave

APR 3 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1944, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1944 to 3/30 1944 and that I last saw him alive on 3/30 1944.

Immediate cause of death Lobar Pneumonia, L.L.L.

Duration 14 d.

Due to

Due to

Other Conditions A.V. hemiplegia (L) Facial palsy Prob. Uraemia

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy: Dr. Dodd

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E L Sergman M.D.

Address B C H. Date signed 3/31

G 15767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

89a

G 15767 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RUR and give town)
(d) Street No. 325 S Paca St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/19/1932

8. AGE: Years	Months	Days	If less than one day
11	9	12	hr. min

9. Birthplace Md (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Lloyd
13. Birthplace Md

MOTHER
14. Maiden Name McKnew
15. Birthplace Md

16 (a) Informant
(b) Address Hosp. Record

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd

18 (a) Funeral director Harry Mitchell
(b) Address 4101 Edmondson Ave

19 (a) (Date received by registrar) APR 3 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1944 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1944 to 3/31 1944, and that I last saw her alive on 3/31 1944.

Immediate cause of death
(a) Bronchopneumonia
Due to Mastoiditis, acute
Due to Chronic otitis media acute
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/31/44
Major findings of operation: same
of autopsy: refused

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. A. Thompson M.D.
Address University Hosp Date signed 3/31/44

G 15768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 Registered No. G 15768

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave
(c) Hospital or institution:
Gen'l German Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8/4
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Amelia Beffen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widow

6 (b) Name of husband or wife late Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10/1863

8. AGE: Years	Months	Days	If less than one day
80	8	20	hr. min.

9. Birthplace German (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Anton Eckschmidt
13. Birthplace German

MOTHER
14. Maiden Name Marie Hartemayer
15. Birthplace German

16 (a) Informant German Home
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md

18 (a) Funeral director Harry H Wiltze
(b) Address 4101 Edmondson Ave

19 (Date received by Registrar) APR 3 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Mch~~ 3/30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 15/44 to Mch. 30/44. and that I last saw her alive on Mch. 28/44

Immediate cause of death — Duration

Broncho-Pneumonia — 15 days.

Due to

Due to

Unknown.

Other Conditions Arterio-Sclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Heed Clauer M.D.
Address 933 Hanover St. Date signed Apr. 1/44.

G 15769 Oakland 1576 9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registration No. G 15769

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2221 Pelham Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice M. Howe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Harold H. Howe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1880

8. AGE: Years	Months	Days	Hours	Min.
63	7	23	Less than one day	

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John B. Elliott
13. Birthplace Maine

MOTHER
14. Maiden Name Ada A. Turner
15. Birthplace Maryland

16 (a) Informant Harold H. Howe
(b) Address 2221 Pelham Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-44 (month) (day) (year)
(c) Cemetery or crematory Oakleigh
Location Eastern Ave

18 (a) Funeral director Harry Witzke
(b) Address 4101 Edmondson Ave

19 (a) Date received by local registrar APR 5 1944 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1944 at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1944 to 4/1 1944
and that I last saw her alive on 4/1 1944

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to

Other Conditions Lobular lung infiltration & pneumonia
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Md. Gen. Hosp. Date signed 4/5/44 M. D.

20

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1218

Registered No. G 15770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 W Calvert Ave
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38d.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Maryland Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Charles Thrift

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 28 March 1891

8. AGE: Years 53 | Months 0 | Days 13 | If less than one day hr. min

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Candy Peddler

11. Industry or business

FATHER
12. Name Jim Thrift
13. Birthplace Virginia

MOTHER
14. Maiden Name Nannie ?
15. Birthplace ?

16 (a) Informant Mrs. P. W. Hynson
(b) Address 5104 S. Edwards Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Sons
(b) Address 1215 St. Paul St.

APR 3 - 1944 (Date rec'd by local registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1944 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Feb. 1944 to April 4th 1944. and that I last saw him alive on April 4 1944.

Immediate cause of death cardio-respiratory failure

Due to uremia

Due to Chronic glomerulo-nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Union Memorial Hosp. Date signed 4-7-44

15771

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G 15771

CERTIFICATE OF DEATH 106 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Marriottsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Ralph Zepp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Laila Bell Zepp

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) 10/5/15

8. AGE: Years	Months	Days	If less than one day
28	5	28	hr. min.

9. Birthplace Marriottsville, Md.
(Town, county, and state)

10. Usual Occupation Bus Driver

11. Industry or business Balto. Motor Coach Co.

FATHER
12. Name Arthur Zepp
13. Birthplace Marriottsville, Md. ?

MOTHER
14. Maiden Name Anna Frances Zepp
15. Birthplace unk.

16 (a) Informant Mrs. Laila M. Zepp
(b) Address 19 Township Road, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4, 1944 (month) (day) (year)

(c) Cemetery or crematory Springfield Cemetery
Location Sykesville, Md.

18 (a) Funeral director C. Harry Deer
(b) Address Sykesville, Md.

APR 3 - 1944 (a) (Date received by registrar) (b) Hunterston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 - 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1944, to April 2, 1944, and that I last saw him alive on April 1, 1944.

	Duration
Immediate cause of death Peripheral Vascular Collapse	5 days
Due to Uremia	5 days ?
Due to Cerebral Edema	? 7 days
Due to Bronchiectasis, left Lung.	
Other Conditions Malnutrition, Exfoliative dermatitis. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Bronchiectasis, cerebral Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Shorb M. D.

Address Redwood & Greene St. Date signed 4/2/44

VS 3

15772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 15772

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 N. Gilmor
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N. Gilmor (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ella Patterson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem	Co	M

6 (b) Name of husband or wife Josiah Patterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 24-1880

8. AGE: Years	Months	Days	If less than one day
63	11	7	hr. min.

9. Birthplace Calvert Co (City, county, and state)
10. Usual Occupation Housework
11. Industry or business

MOTHER / FATHER

12. Name Elijah Johnson
13. Birthplace Md
14. Maiden Name Minnie A. Taylor
15. Birthplace Md

16 (a) Informant Josiah Patterson
(b) Address 921 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 4-1944 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Emoly's Calvert Co

18 (a) Funeral director Daniel N Chase & Son
(b) Address 638 N. Gilmor St

19 (a) (Date rec'd by local registrar) Registrar

APR 3 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2- 1944 to 3/31- 1944, and that I last saw h alive on 3-30- 1944.

Immediate cause of death Cardiac Dilatation
Due to Anasarca
Due to Myocarditis
Other Conditions Arteriosclerosis, Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R Boykin M.D.
Address 1135 Eutaw Date signed 4/1/44

15773

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

952

G 15773
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 561 Laurens St.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) -14

(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 561 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Camilla P. Wiel Monk

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife J. Roosevelt Monk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 3, 1912

8. AGE: Years	Months	Days	If less than one day: hr.	min.
31	11	27		

9. Birthplace Northampton Co. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wiel
13. Birthplace Va.

MOTHER
14. Maiden Name Susie Kellam
15. Birthplace Va.

16 (a) Informant Susie Wiel (mother)
(b) Address 561 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Balto. Co. Md.

18 (a) Funeral director John M. Thomas
(b) Address 1700 Druid Hill Ave

APR 3 - 1944 (Date rec'd by Registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30" 1944 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1943 to Mar. 30 1944 and that I last saw h[illegible] alive on Mar. 30 1944.

Immediate cause of death: Congestive Heart Failure — Duration: 2 weeks
Due to: Rheumatic Heart Disease — Duration: 6 months
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Randolph W. Perkins Jr. M.D.
Address 426 N. Fulton Ave Date signed 4/1/44

correct age is especially important

VS 180

G 15774

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 15774 Registered No.

CERTIFICATE OF DEATH 937

PLEASE WRITE CLEARLY with pen and ink. Use typewriter preferably. Do not abbreviate. Give full name of deceased. If not in hospital or institution, give residence instead of institution. If residence is unknown, give length of residence in place where death occurred. If deceased was a child, give name of father or mother. Do not report stillbirths. If child lived only a few hours, or was still-born, write "Stillborn." If born dead, write "Born dead." If born alive, write "Born alive." If death occurred within 24 hours after birth, also fill out a Certificate of Birth. If deceased was married, widowed, or divorced, give name of husband or wife. If deceased was a married woman, give her maiden name. If deceased was single, give name of father or mother. If deceased was a child, give name of father or mother

15775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15775

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 Eutaw Place.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 Eutaw Place.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME EDWARD FRANK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Lena Sussman Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8th. 1866.

8. AGE: Years 77 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Ellicott City, Md.
(Town, county, and state)

10. Usual Occupation Paper Salesman.

11. Industry or business

FATHER
12. Name Siegfried Frank.
13. Birthplace Berlin.

MOTHER
14. Maiden Name Annie Rosenheim.
15. Birthplace Balto. Md.

16 (a) Informant Mrs. E. Sussman,
(b) Address 2416 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44. (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levin & Son
(b) Address 1902 Eutaw Place.

19 (a) [illegible] (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st. 1944, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1944 to 4/1 1944, and that I last saw h[illegible] alive on 4/1 1944.

Immediate cause of death
Acute Pulmonary Edema
Due to Chronic Myocarditis
Due to Arterio-sclerosis & hypertension
Other Conditions None

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

Duration: 1 hr. 12 hr. 1 day 2 days 1 week 2 weeks 1 month 2 months 6 months 1 year 2 years 5 years 10 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Herman Siegel M.D.
Address 2404 Eutaw Place Date signed 4/7/44

VS 8

15776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 15776
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 Reisterstown Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
a. State Md b. County
c. City or town Baltimore
(If outside city or town limits, write RURAL and give town)
d. Street No. 3809 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WEISBERG, TILLIE
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife David
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13. 1885

8. AGE: Years	Months	Days	If less than one day
58	6	20	hr. min

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Ididore Sacks
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mr Samuel Weisberg
(b) Address 3809 Reisterstown Road

17 (a) Burial (b) Date thereof April 3, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Road
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 APR 3 - 1944 Huntington Williams M.D.
(Date received by local registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 2 1944. 6:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1944 to April 2 1944. and that I last saw her alive on April 2 1944.

Immediate cause of death: Cardiac failure — Duration
Due to Myocardial insufficiency
Due to Coronary occlusion
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isadore Horofsky M.D.
Address 601 N Monroe Date signed Apr 3 1944

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure your answer to each question is complete and correct age is especially important.

15777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 R

G 15777 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2557 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2557 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriette Louise Cole

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Harry Cole
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1871

8. AGE: Years	Months	Days	If less than one day
72	11	15	hr. min.

9. Birthplace Eastport, A.A. Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jonas Williams
13. Birthplace Sweden

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Jack Williams
(b) Address Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18 (a) Funeral director E. W. Lamaeumus
(b) Address 1003 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 3 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 1 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1943 to Apr 1 1944, and that I last saw h[illegible] alive on Apr 1 1944.

Immediate cause of death	Duration
Pneumonia	4½ days
Due to	
Due to	
Other Conditions Pneumonia Erysipelas (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Apr 2 1944

Correct age [illegible]

G 15778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15778 ✓ 46E

Registered No. .....

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Calloway Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME IDA A. WRIGHT

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1873

8. AGE: Years	Months	Days	If less than one day
70	7	20	hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles W. Dasch
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Knight
15. Birthplace Md.

16 (a) Informant Mrs. Mary D. Bagley
(b) Address 3404 Calloway Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ADD (Date received by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1944, at 9 75 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1944, to 4/1 1944, and that I last saw h Et alive on 4/1 1944.

Immediate cause of death	Duration
Intestinal obstruction	2 weeks
Due to Cancer of colon	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3/20
Major findings of operation: Cancer of colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. W. Dwyer M.D.
Address St. Agnes Hosp Date signed 4/1/44 (M. D.)

G 15779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G 15779
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 944 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie May Fauver
3 (b) If veteran, name war --
3 (c) Social Security Account No. --
4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Oscar W. Fauver
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3-18-89
8. AGE: Years 55 Months 0 Days 14 If less than one day hr min
9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business
FATHER 12. Name Joseph Hoff
13. Birthplace ?
MOTHER 14. Maiden Name Dora Siss
15. Birthplace ?
16 (a) Informant records
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944 at 4:20 P.M.
21. I certify that death occurred on the date above stated, that I attended deceased from April 1 1944 to April 2 1944 and that I last saw h-- alive on April 2 1944.

	Duration
Immediate cause of death: Cardiac failure with pulmonary oedema & hepatomegaly	3 days
Due to: Hypertensive cardio-vascular disease	2 yrs +
Due to	
Other Conditions: Diabetes Mellitus	15 yrs +

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert E. Farber
Address Johns Hopkins Hospital Date signed 4/2/44 M. D.

VS 160

G 15780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 15780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write (C.) or (T.) and give town)
(d) Street No. 2312 Chelsea Terr.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Alfred M. Quick (Alfred Merritt Quick)
3 (b) If veteran, name war None
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~

6 (b) Name of husband or wife Loury Nunn Quick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1867

8. AGE: Years 77 | Months 1 | Days 22 | If less than one day: hr. min

9. Birthplace Seymour, Conn. (Town, county, and state)

10. Usual Occupation Civil Engineer-Retired
11. Industry or business U. S. F. & G. Co.

FATHER
12. Name Rev. Abram J. Quick
13. Birthplace N. J.

MOTHER
14. Maiden Name Frances Merritt
15. Birthplace Boston, Mass.

16 (a) Informant Mrs. Barbara Q. Fingles
(b) Address 2312 Chelsea Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address APR 3 Balto., Md.

19 (a) (Date rec'd by registrar) (b) (c) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31- 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1944 to 3/31/1944, and that I last saw h/ M alive on 3-31 1944

Immediate cause of death: Pulmonary Edema — Duration: 3-28

Due to Uremia + Myocardial Failure — 3-31

Due to Renal Failure from chronic nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-26

Major findings of operation: Enlarged Benign Prostate

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Hosp. Date signed 4-1

PHYSICIAN
Underline the cause to which death should be charged statistically

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15781
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3436 University Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md.
(b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3436 University Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH M. J. BALDWIN

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widow

6 (b) Name of husband or wife Dr. Silas Baldwin

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 4/9/1869

8. AGE: Years	Months	Days	If less than one day
74	11	22	hr min

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Patrick Carey Baldwin
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Ireland

16 (a) Informant Mrs. Harry C. Michael
(b) Address 3436 University Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 2 - 1944
(Date received by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Apr. 1, 1944, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938, to Apr 1 1944.
and that I last saw her alive on Mar. 31 1944.

Immediate cause of death Arteriosclerotic heart disease — Duration 6 yrs

Due to arteriosclerosis

Due to

Other Conditions Bronchopneumonia — 3 days
(Include pregnancy within 3 months of death)

PHYSICIAN
Underline the cause to which death should be charged statistically

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Novak

Address 101 W. Read St. Date signed 4 M 3 D '44

15782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 15782 (42 Y)

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 N. Spring St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. Spring St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Hinton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1884

8. AGE Years 60 | Months 1 | Days 29 | If less than one day: hr. min.

9 (a) Birthplace Unknown
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Hinton
13. Birthplace unknown

MOTHER
14. Maiden Name Blanch, D. Thompson
15. Birthplace Maryland

16 (a) Informant Thelma H. Hinton
(b) Address 1006 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 5 44 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Baltimore Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1721 Jefferson St

19 (a) APR 3 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31/44 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Injection-Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ✓, accident ( ), suicide ( ), homicide ( ), undetermined ( ) and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature Charles J. Gilbert M.D.
Medical Examiner
Date signed 7/1/44

VS 151

G 15783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 Penna ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 Penna ave
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME David G. Harrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. 211-12-6200

4. Sex M | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Antha Harrison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1905

8. AGE: Years 38 | Months 3 | Days 5 | If less than one day hr. min

9. Birthplace md (Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name Winfield Harrison
13. Birthplace md

MOTHER
14. Maiden Name Minerva Moore
15. Birthplace md

16 (a) Informant Antha Harrison
(b) Address 1805 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George G. Kelson
(b) Address 1203 Pennsylvania Ave

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

6

APR 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1944, at 3:40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Mar 1 1944 to Mar 31 1944 and that I last saw h— alive on Mar 30 1944

Immediate cause of death: Bronchopneumonia
Duration: 3 wks
Due to: Influenza
Due to:
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible]
Address 5 [illegible] Date signed 4.1.44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 15784

Registered No. 1212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 Pressman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Pressman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Woodlee

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/18/1886

8. AGE: Years 57 | Months 2 | Days 12 | If less than one day hr min

9. Birthplace Va (Town, county or state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Chas Boles
13. Birthplace Va

MOTHER
14. Maiden Name Sophia ?
15. Birthplace Va

16 (a) Informant Eltha McLizan
(b) Address 401 Pressman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1944, at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1944 to 3/30 1944, and that I last saw him alive on 3/30 1944

Immediate cause of death Chr. Nephritis — Duration

Due to Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burkett M. D.
Address 1139 Dolphin St Date signed 3/31/44

VS 150

Physicians: please write the cause of death clearly and legibly. Especially important.

G 15785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 | a

G 15785

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 myrtle ave
(c) Hospital or institution: Balto md

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 myrtle ave (If rural give location)

(e) If foreign born, how long in U. S. A.) years

3 (a) FULL NAME Calvin Young

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3 1894

8. AGE: Years	Months	Days	If less than one day
49	5	26	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Josiah Young
13. Birthplace Balto Md

MOTHER
14. Maiden Name Annie Grutt
15. Birthplace Balto Md

16 (a) Informant Annie Baker
(b) Address 1316 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943, to Mar 29 1944, and that I last saw h[illegible] alive on Mar 28 1944

Immediate cause of death	Duration
Cardio-Vascular-Renal Disease	12 mos
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. J. Hughes M. D.

Address [illegible] Fremont Date signed 4-3-44

VS 3

G 15786

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15786 ✓ 186a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 Walnut ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Walnut ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Edward Day

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: M Donna Day.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 17, 1884

8. AGE: Years	Months	Days	If less than one day
59	7	14	hr. min.

9. Birthplace: Maryland.
(Town, county, and state)

10. Usual Occupation: Retired Naval Service
11. Industry or business

FATHER
12. Name: Edward Day
13. Birthplace: Md.

MOTHER
14. Maiden Name: Florence Cross
15. Birthplace: Md.

16 (a) Informant: Mrs. M. Donna Day.
(b) Address: 807 Walnut Ave, Baltimore, Md

17 (a) Burial (b) Date thereof 4-4-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Baltimore, Md

18 (a) Funeral director: F.C. Heginbotham
(b) Address: Ellicott City, Md.

19 (a) APR 3 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1- 19KK, at 2:40 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 28 c

(a) Date of injury 4-1-44 at 2.15 A M.
(b) Where did injury occur? 807 Walnut ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down flight main stairs

23. Signature Howard J. Weaver, M.D.
Medical Examiner.
Date signed 4-1-44

VS 151

15787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 15787
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 E. FAIRMOUNT AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 / 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 E. FAIRMOUNT. (If rural give location)
(e) Citizen of foreign country? (Yes or No) AVE
If yes, name country

3 (a) FULL NAME HILDA PACHINO

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife LOUIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant LOUIS PACHINO
(b) Address 1701 E. FAIRMOUNT AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-3-44 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location O'DONNELL ST.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 APR 3 - 1944 (Date received by registrar) (b) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION

28. DATE OF DEATH 4-2-44 19 30 , at 12. P.M

21. I certify that death occurred on the date above stated; that I attended deceased from November 19 39 to April 19 44.
and that I last saw her alive on April 1 19 44.

Immediate cause of death Diabetes Mellitus — Duration 7 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon M. D.
Address 129 S. Bway Date signed 4/2/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

15788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ G 15788 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave.
(c) Hospital or institution:
Hebrew Home for Aged & Infirm ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Schneer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Bernard Schneer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 85 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Married wife

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-44 (month) (day) (year)
(c) Cemetery or crematory Mishkin Forest
Location Northern Ave
18 (a) Funeral director Joseph Levin Inc
(b) Address 1439 E. Balto St
19 (a) (Name of city or registrar) Huntington Williams (Deputy)

APR 5 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20-1942, to 4-3 1944, and that I last saw h[illegible] alive on April 3 1944.

Immediate cause of death: Right cerebral haemorrhage
Hypertension, Chr card. vas disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin
Address Levindale Date signed 4/3/44

G 15789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 147a

G 15789
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sundale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Falcon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peare, Mrs. Johnston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Peare, Mr Isaac.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1918

8. AGE: Years	Months	Days	If less than one day
25	11	8	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name Otho Hale
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Noreene Johnson
15. Birthplace N. Carolina

16 (a) Informant Mrs. Isaac Peare
(b) Address 1801 Falcon Ave, Sundale

17 (a) BURIAL (b) Date thereof 4/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory EDGEWOOD
Location WINDSOR. N.C.

18 (a) Funeral director CLARENCE F. HOFFMANN
(b) Address 1639 N. BROADWAY

19 (a) APR 3 1944 (b) Huntington Williams Hoff
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1944. to April 2 1944. and that I last saw h[illegible] alive on April 2 1944.

Immediate cause of death Anuria -
Duration

Due to Prolonged Shock

Due to Uremic apoplexy + atonia
Pyelonephritis, left

Other Conditions Pregnancy - 8 mos del.

(Include pregnancy within 3 months of death)
Date of operation Delivered 4-1-44
Major findings of operation:

of autopsy: Pyelonephritis; uremic apoplexy.

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isabella Harrison M. D.
Address Church Home + Hosp Date signed 4.3.44.

Physicians: please write the causes of death clearly and legibly. Be as accurate as necessary important.

G 15790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15790 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Crawley Page

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1906

8. AGE: Years 37 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Robert Crawley
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Ella Booker
15. Birthplace Richmond, Va.

16 (a) Informant Alberta Epistein
(b) Address 3908 E. Lee St. Richmond, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12 1937 (month) (day) (year)
(c) Cemetery or crematory Asbury Mem. Pk. Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Registrar
Interred by removal

APR 3 1937

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1937, at 6 28 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1937, to 3-29 1937, and that I last saw h er alive on 3-29 1937.

Immediate cause of death Hypertension

Due to Cadiovascular Disease

Due to

Other Conditions To be approved by medical Examiner (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. L. Banfield M. D.
Address Provident Hospital Date signed 3/29/37

Dr Geo H Holland allen number MD Assistant Coroner

5791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G 15791

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 37 N. Ellamont St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 37 N. Ellamont St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hilda S. Landon

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John F. Landon 6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) April 20 - 1899

8. AGE: Years	Months	Days	If less than one day
44	11	10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John P. Dimitrius

13. Birthplace Md.

MOTHER 14. Maiden Name Emma F. Eichner

15. Birthplace Md.

16 (a) Informant John F. Landon

(b) Address 37 N. Ellamont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md

18 (a) Funeral director F. B. Hesselbrock Inc

(b) Address 459 N. Baltimore St

19 (a) APR 3 - 1944 (b) (Date rec'd by registrar) Huntington Williams, M.D., Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944, at 1.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943, to March 30 1944, and that I last saw h alive on March 30 1944;

Immediate cause of death Cerebromeningitis (Due to) Cerebral Compression (Due to) Fracture of Petrous Bone

Due to Injury of Spine

Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert L. Nichols M. D.

Address 251 Wilkens Ave Date signed 4/3/44

15792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 15792
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert J. Hook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name ~~of husband~~ or wife Myrtle Hook
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 6 - 1888

8. AGE: Years	Months	Days	If less than one day
56	-	24	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Upholstering - Refining
11. Industry or business Upholstery Co

FATHER
12. Name Samuel R Hook.
13. Birthplace Pa

MOTHER
14. Maiden Name Elizabeth Selack
15. Birthplace Md

16 (a) Informant Myrtle Hook W
(b) Address 2426 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director J. A. Hoffman & Son
(b) Address 850 N. Eutaw St Balto

19 (a) APR 3 - 1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1944 at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1944 to 3/30 1944, and that I last saw h ~~s~~ r alive on 3/30 1944.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at .....M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Byrne
Address St. Agnes Hosp Date signed 4/10/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15793 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Jackson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Susie R. Bevan

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Thomas Bevan
13. Birthplace Wales

MOTHER
14. Maiden Name Susan Philippe
15. Birthplace Wales

16 (a) Informant Mrs. Mary McCorkle
(b) Address Box 84 Sparrows Pt. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Fort Ave.

19 (a) (Date received by registrar) APR 3 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Injury of Brain

Due to Generalized arteriosclerosis

Other Conditions Arteriosclerotic gangrene of left leg (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 2 1944

FVS 181

G 15794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 44a

G 15794 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 S.Curley Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24, (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 S.Curley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maximilian Olszewski OR Price

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-7498

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Viola Kaczmarek
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) October 25-1890

8. AGE: Years	Months	Days	If less than one day
53 54	5	8	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Stock Clerk
11. Industry or business Hecht Bros,

FATHER
12. Name Michael Olszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Michalena Sadowski
15. Birthplace Poland,

16 (a) Informant Mrs. Viola Olszewski (Wife)
(b) Address 532 S.Curley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, City, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) APR 3 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1944, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 2 1944, to Apr 3 1944, and that I last saw h[illegible] alive on Apr 3 1944.

Immediate cause of death: Coronary Occlusion — Duration 4-2 44

Due to: none

Due to:

Other Conditions: none.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence none at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 4-3-44 M. D.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure that the information given in items 20 to 22 is correct and complete. Accuracy in stating the cause of death is especially important.

15795

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15795
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Park Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Francis Groeninger
3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widower

6 (b) Name of husband or wife Mamie Nieman Groeninger
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 6, 1863

8. AGE: Years	Months	Days	If less than one day
80	10	26	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Groeninger
13. Birthplace Holland

MOTHER
14. Maiden Name Kaiss
15. Birthplace Germany

16 (a) Informant JEROME W. GROENINGER
(b) Address 510 PARK AVE

17 (a) Burial (b) Date thereof 4/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Clay J. Eugene Forbes
(b) Address 118 W. Mt. Royal Ave

19 APR 3 - 1944 (b) Hunter Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2. 1944 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1944 to 4/2 1944.
And that I last saw him alive on 4/2 1944.

Immediate cause of death Broncho-pneumonia — Duration 12 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Sigmund Kruger M.D.
Address Bon Secours Hosp Date signed 4/3/44

VS 3

G 15796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15796 Registered No.

PLEASE PRINT plainly; use ink; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 S. Hanover st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 S. Hanover st (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Emma F. Kuhn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Edward Kuhn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
74	3	8		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name James T. Smith
13. Birthplace Md

MOTHER
14. Maiden Name Mary Star
15. Birthplace Md

16 (a) Informant Miss Doris Snow
(b) Address 1509 S. Hanover st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East End North ave

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Rd

19 (a) (Date received) APR 3 - 1944 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944, at 7 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1944, to 4/2 1944, and that I last saw h[illegible] alive on 4/1 1944

Immediate cause of death Hypertensive Cardio vascular disease — Duration 4 yr

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Weiler
Address 226 Hamburg st Date signed 4/3/44 D

G 15797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 15797

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2834 Kentucky Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2834 Kentucky Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Carey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1853

8. AGE: Years	Months	Days	If less than one day
90	10	21	hr. min.

9. Birthplace Phila Pa (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John P. Carey

13. Birthplace Ireland

MOTHER 14. Maiden Name Hannah Sullivan

15. Birthplace Ireland

16 (a) Informant Mr. Joseph A. Carey

(b) Address 2834 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director Samuel J. Mark

(b) Address 5305 Harford, R.D. Phone Belair Mitchellville, Md.

19 (a) (Signature of registrar) (b) Registrar

APR 3

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 1944 to 3/31 1944, and that I last saw h. alive on 3/31 1944.

Immediate cause of death

Fracture femur

Due to

Due to

Other Conditions Myocardial degeneration

(Include pregnancy within 3 months of death)

Duration 2 days

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. A. Carey

Address 2834 Kentucky Ave Date signed 4/4/44

G 15798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G 15798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon 2101 W Fayettock
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 Ramsay st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Matilda Leonard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry J Leonard (Deceased) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4-1867

8. AGE: Years	Months	Days	If less than one day
76	5	26	7 hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Stevens

13. Birthplace Md Ohio

MOTHER 14. Maiden Name Mary J. Covell

15. Birthplace Md

16 (a) Informant Mr. Lemon Leonard

(b) Address 117 N Catherine st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl. 4-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park.

Location Balto Md

18 (a) Funeral director Geo. L. Berger Jr

(b) Address 1972 Hollins St

19 (a) (b)
(Filled by registrar)

APR 3 - 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1944, at 6.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1944, to 3/31 1944, and that I last saw her alive on 3/31 1944.

Immediate cause of death Pulmonary Edema

Due to Bron Pneumonia & Arteriosclerosis

Due to C.A. & Stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration, 1 day, Hospital - 3 wks at home.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify place)
(e) Means of injury

23. Signature Chas Worthington Jr. M. D.

Address Bon Secours Hosp. Date signed 3/31/44

5799 Reserve #3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓183

G 15799
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Pier #3 Locust Point
(d) Length of stay in hospital or inst. (yrs., mos., or days) Unknown
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Unknown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown Male

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Unknown 30			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location APR 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 3 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3-44 1944, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Unknown M.
(b) Where did injury occur? Unknown
(c) Did injury occur at home, on farm, industrial place, in public place? Unknown While at work?
(d) Means of injury Found ground

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 3 1944

G 15800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Hunter St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Hunter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgianna Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband ~~or wife~~ Joseph Hill
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Rebecca Roberts
15. Birthplace Va

16 (a) Informant Joseph Hill
(b) Address 2202 Hunter St.

17 (a) Burial (b) Date thereof 4/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. Co.

18 (a) Funeral director Robert E. Jennings
(b) Address 1501 Madison Ave.

19 (a) APR 3 - 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944, at 10:58 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Uremia nephritis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 31 1944

VS 151

G 15801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G 15801
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2564 W Baltimore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 63

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2564 W Baltimore St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME George Regester Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No. 214-01-3952

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lillian B. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 1880

8. AGE: Years	Months	Days	If less than one day
63	8	27	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business Prudential Ins Co

FATHER
12. Name Chas A Johnson
13. Birthplace Anne Arundel Co Md

MOTHER
14. Maiden Name Martha Stewart
15. Birthplace Howard Co Md

16 (a) Informant Lillian B. Johnson
(b) Address 2564 W Baltimore St

17 (a) Burial (b) Date thereof April 1944
(Burial, cremation, or removal) (month, day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry P. Irwin
(b) Address 1720 Pennsylvania Ave

19 (a) APR 3 1944 (b) Registrar
(Date received by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2, 1944, to April 2, 1944, and that I last saw h alive on April 2, 1944.

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to Arteriosclerosis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar A Kemp M. D.
Address Date signed April 3, 44

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G 15802

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 82a

G 15802
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made in this office before burial permit is issued. Use only black ink. Physicians: please write the causes of death clearly and legibly. Give correct age in all cases where it is known. Answer every question; if information cannot be secured, state the reason why. The word "about" before an age, or the omission of the age, will not be sufficient. Be sure that the date of death is complete. Do not abbreviate. Write out the full name of the cause of death. The cause of death must be certified to by a physician, if there was one in attendance, and by the coroner in all cases where he holds an inquest. Midwives and undertakers are not authorized to certify to the cause of death. Do not report "Heart Failure" as the cause of death without stating what caused the heart failure. Deaths from violence must be reported to the Coroner immediately.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2639 Boone St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2639 Boone St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alvina Gassaway

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 - 1892

8. AGE: Years 51 52 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Augustaus Gassaway
13. Birthplace Md

MOTHER 14. Maiden Name Sarah ?
15. Birthplace Md

16 (a) Informant Celeste Hughes
(b) Address 2639 Boone St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31-44 19 . at 11¾ M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17-44 19 to 3-31- 1944. and that I last saw h[illegible] alive on 3-31- 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 wks
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Adams, M. D.
Address 312 E 23rd St Date signed 4-7-44

VS 150

G 15803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15803 Registered No. 121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9wks 4dys
(e) Length of stay in Baltimore (yrs., mos., or days) 12yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Silver Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ellen O'Connor.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1931

8. AGE: Years	Months	Days	If less than one day
12	3	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Joseph A. O'Connor
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Vaeth
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Joseph A. O'Connor
(b) Address 2911 Silver Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Baltimore, Md.

18 (a) Funeral director H. G. Hoffberger & Sons, Inc.
(b) Address

19 (a) (Date received by registrar) APR 3 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1944, at 6 18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9. 1944, to April 1 1944, and that I last saw her alive on April 1 1944.

Immediate cause of death Respiratory failure — Duration ½ hr.
Due to General systemic weakness — Duration 7½ weeks
Due to Ruptured appendix & generalized peritonitis — Duration 7½ weeks
Other Conditions Abdominal drainage & cecostomy
(Include pregnancy within 3 months of death)
Date of operation Feb 9, 1944
Major findings of operation: Ruptured Appendix & Peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Z. Berry, M.D.
Address Mercy Hospital Calvert & Saratoga Sts. Date signed 4/1/44

G 15804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15804 / 121

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: St Joseph's Hospital
(a) Baltimore City, Maryland
(b) Street address 1100 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 S Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Vistoria Orlowski

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Raymond Orlowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1893

8. AGE: Years 50 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business at Home

FATHER
12. Name Walenty Ozmunski
13. Birthplace Poland

MOTHER
14. Maiden Name Zapiko
15. Birthplace Poland

16 (a) Informant Raymond Orlowski
(b) Address 524 S Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozmunski
(b) Address 1900 Eastern Ave.

19 (a) APR 3 1944 (Date received by registrar) (b) Harding to Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1944 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1944 to March 31 1944, and that I last saw h or alive on March 31 1944.

Immediate cause of death: Lobar Pneumonia
Acidosis

Due to: Diabetis Mellitus

Due to: Acute perforated apendicitis

Other Conditions: Phophritis
(Include pregnancy within 3 months of death)

Date of operation March 8/44

Major findings of operation: Acute ruptured apendicitis

of autopsy: not obtained

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Ballweg M. D.
Address St Joseph's Hosp Date signed 3/31/44

G 15805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15805 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 923 S Sharp Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 923 S Sharp Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1896

8. AGE: Years	Months	Days	If less than one day hr.	min.
48				

9. Birthplace West Va (Town, county, and state)

10. Usual Occupation Sepl

11. Industry or business —

FATHER 12. Name Unknown

13. Birthplace " "

MOTHER 14. Maiden Name Unknown

15. Birthplace " "

16 (a) Informant Thomas J Clemons

(b) Address 1021 S Holland Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A.A. Co. Md

18 (a) Funeral director Isaiah L Brown Son

(b) Address 108 W Montgomery Street

19 (a) APR 3 - 1944 (Date received by Registrar) Registrar

VS 180

Huntington Howard Hill, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 28 19 44 to Apr 1 19 44 and that I last saw h alive on Mar 28 19

Immediate cause of death	Duration
(a) Acute Endocarditis	unknown
Due to (b) Rheumatic Infection	unknown
Due to	
Other Conditions ?	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 4/5/44

15806 451 216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 15806 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. Arundel
(c) City or town Annapolis (If outside city or town limits, write RURAL, and give town)
(d) Street No. 20 Fleet St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Geri Henson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	black	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/44

8. AGE: Years	Months	Days	If less than one day
		12	hr min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard Henson
13. Birthplace Md.

MOTHER
14. Maiden Name Consola
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 3 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 APR 3 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1944, at 5 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18 1944 to Mar. 30 1944 and that I last saw h-- alive on Mar 30 1944.

Immediate cause of death Respiratory failure

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp Date signed 3-30-44

0842

15807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. C 15807

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day

(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 837 Rutland Ave.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME

Baby Thomas

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Balck	single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 26, 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER — 12. Name Charles Thomas

13. Birthplace Virginia

MOTHER — 14. Maiden Name Lottie Davis

15. Birthplace Maryland

16 (a) Informant Hospital records

(b) Address Johns Hopkins Hospital

17 (a) ..... (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 3 1944
Commissioner of Health

18 (a) Funeral director .....

(b) Address .....

19 APR 3 1944 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 160

10841

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944, at 8.A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1944, to March 27 1944, and that I last saw him alive on March 27 1944.

Immediate cause of death Intracranial hemorrhage

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

Duration

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Philip P. Stephens, M.D.

Address Johns Hopkins Hospital Date signed 3-30-44

Please see is especially important. Physicians: please write the causes of death clearly and legibly.

15808 451743

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15808
Registered No. 159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Forest
(If outside city or town limits, write RURAL and give town)
(d) Street No. 142½ Hoffman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy (B) Ringham

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-44

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Vernon Ringham
13. Birthplace Md.

MOTHER
14. Maiden Name Edie Kirby
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D.

19 APR 3 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch-29- 1944, at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch-25 1944, to Mch 29 1944, and that I last saw him alive on Mch-29 1944.

Immediate cause of death Respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address John Hopkins Hosp Date signed 3-29-44

0840

451356 G 15809

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12R

G 15809
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL, and give town)
(d) Street No. 120 S. Bethel (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME ARTHUR Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	BLACK	Widowed ~~Married~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-18-90

8. AGE: Years	Months	Days	If less than one day
53	9	13	hr min

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation TEAM HAULING
11. Industry or business

FATHER
12. Name John Lee
13. Birthplace N.C

MOTHER
14. Maiden Name SARAH BYNUM
15. Birthplace N.C

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location A. A. County Md

18 (a) Funeral director Joseph L. Lukes Jr.
(b) Address 1304 N. Central Ave

19 (a) (Date rec'd by registrar) APR 3 - 1944 (b) Registrar Huntington Hitt

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 31 1944, at 8 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 22 1944, to MAR 31 1944, and that I last saw him alive on MAR 31 1944.

Immediate cause of death Pneumonia

Due to

Due to Tuberculous broncho-pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cohen M. D.
Address J. Hopkins Date signed 4-1-44

15810

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

G 15810
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Edgemere
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 S. 52nd St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard M. Klemm

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-01-9556

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married (Widowed)

6 (b) Name of husband or wife: Hilda Kelley

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Sept. 17-1901

8. AGE: Years 42 | Months 6 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Sheet metal Worker

11. Industry or business Klemm Plumbing Co.

FATHER
12. Name Max J. J. Klemm
13. Birthplace Germany

MOTHER
14. Maiden Name Meta Ullrich
15. Birthplace Germany

16 (a) Informant Mrs. Hilda Klemm
(b) Address 413 S. 52nd St.

17 (a) Burial (b) Date thereof Apr. 4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John J. Connelly
(b) Address 418 Eastern Ave Essex

19 (a) APR 3 - 1944 (b) Edw. F. Nitkiewicz, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31- 1944, at 3 P. M

21. I certify that I took charge of the remains described above, held an autopsy - Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 53-00

(a) Date of injury 3-31 [redacted] at 3 P. M.
(b) Where did injury occur? [redacted] Point Rd - Sparrows Point Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fell off roof - house.

23. Signature Howard J. Adelsis M.D.
Medical Examiner.
Date signed 4-1-44

VS 151

G 15811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 30E

G 15811 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 N. Fremont ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 N. Fremont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Argent.

3 (b) If veteran, name war

5 (a) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Deserted

6 (b) Name of husband or wife —
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 12-26-1900

8. AGE: Years	Months	Days	If less than one day
43	3	5	____ hr. ____ min.

9. Birthplace North Carolina (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Argent ?
13. Birthplace

MOTHER
14. Maiden Name Mary Moser.
15. Birthplace N. C.

16 (a) Informant Cornelia Harris
(b) Address 726 N. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

19 (a) ____ (Date rec'd by local registrar) (b) Huntington Williams M.D.

APR 3 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 31 - 1944 at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1944 to 3-31- 1944, and that I last saw him alive on 3-27- 1944

Immediate cause of death: Acute Dilatation of heart — Duration Between Onset & Death: ____

Due to Very marked Cardiac Hypertrophy

Due to ____

Other Conditions Possible Luetic (as above) in origin

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm H. Barnes M. D.
Address 611 N. Carolina Date signed 4-3-44

from H. Cargill

Form 230

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 15812 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 N. Bentalou St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Bentalou St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie M. Farnan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John J. Farnan

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 21-1886

8. AGE: Years: 57 | Months: 5 | Days: 11 | If less than one day: hr. min

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: Housekeeper

11. Industry or business

FATHER
12. Name: Thomas A Bell
13. Birthplace: Md

MOTHER
14. Maiden Name: Mary Cook
15. Birthplace: Washington D C

16 (a) Informant: Helen M. Farnan
(b) Address: 5 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/4/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md

18 (a) Funeral director: F. B. Kuhnert Son
(b) Address: Baltimore, Monroe St

19 (a) (Date received by registrar) (b) (Registrar)

APR 3 - 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st 1944, at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1944 to Apr 1 1944, and that I last saw her alive on Apr 1 1944.

Immediate cause of death Coronary Occlusion — Duration: 2 hrs

Due to: Hypertension & Arteriosclerotic Heart Disease — Duration: ?

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Carl Rostring
Address 1816 N Lombard St Date signed 4/3/44 M. D.

G 15813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15813 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Johns Lane & Fred. Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emmitt M. Hardman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Frances L. Hardman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1885

8. AGE: Years	Months	Days	If less than one day
58	4	1	hr. min.

9. Birthplace Emmitsburg (Town, county, and state)
10. Usual Occupation Restaurant
11. Industry or business Business

FATHER
12. Name Harry Hardman
13. Birthplace Emmitsburg

MOTHER
14. Maiden Name Elvira Sleas
15. Birthplace Emmitsburg

16 (a) Informant Frances L. Hardman
(b) Address Ellicott City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 5, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Johns Md. Sec 5 Lot 4
Location St. Johns Ellicott City

18 (a) Funeral director Gaston Sons
(b) Address Ellicott City, Md

19 (a) Date received APR 4 1944 (b) Registrar Huntington Millinus M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1944, to April 1 1944, and that I last saw h[illegible] alive on 4/1/1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Raffucci - Coroner
M. D.

Address Date signed

G 15814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 15814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4420 Shirley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4420 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Kisch

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Henry Kisch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1860

8. AGE: Years 83 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Anthony Haengschmidt
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John E Reinhardt
(b) Address 4420 Shirley Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 4/5/44
(c) Cemetery or crematory Westview
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1314 E Monument St

(a) Date received (month) (day) (year) APR 4 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1939 to April 2 1944, and that I last saw him alive on April 1 1944

Immediate cause of death
Ch. Myocarditis
Due to Arteriosclerosis
Ch. Hypertension
Due to
Other Conditions —
(Include pregnancy within 3 months of death)

Duration 5 years

Date of operation
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J S Hardesty
Address 4810 Belair Rd Date signed April 3 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made for each item. Do not omit any item or correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 15815
JL - 87111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

G 15815
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as required by law. Physicians: please write the causes of death clearly and legibly. Information as to age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alberta Moir

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Franklin Moir
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1912

8. AGE: Years	Months	Days	If less than one day
31	9	20	hr min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Bowling
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Justice
15. Birthplace Ky

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore Md

18 (a) Funeral director Wilson Conf. Co.
(b) Address 1217 E. Fort Ave

19 (a) 4-1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/44 19 , at 4:10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24/44 19 to 4/2/44 19 ,
and that I last saw h[illegible] alive on 4/2/44 19 .

Immediate cause of death: Pulmonary TBC — Duration: 3 / 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M.D.
Address B C H Date signed 4/5

G 15816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 15816
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 N. Charles St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 N. Charles St. (If rural give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. John Joseph Kearns
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mrs. John J. Kearns
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Sept 11, 1904
8. AGE: Years 39 | Months 7 | Days 22 | If less than one day: hr. 21 min.
9. Birthplace New York, N.Y. (Town, county, and state)
10. Usual Occupation Construction Iron Work.
11. Industry or business

FATHER
12. Name John S. Kearns (D)
13. Birthplace N.Y.

MOTHER
14. Maiden Name Rose McGill
15. Birthplace N.Y.

16 (a) Informant Mrs. John J. Kearns
(b) Address [illegible]

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4-4-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director William Cox
(b) Address 1217 St. Paul St.

19 (a) ..... (b) .....
(Date received by registrar) Registrar

APR 4 - 1944

78 180

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944, at 11:52 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to April 2 1944, and that I last saw him alive on 4-2 1944.

Immediate cause of death Cardio-Respir failure — Duration 5 days (?)

Due to Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Mungaterpd Jr. M. D.
Address 322 E. University Pkwy. Date signed 4/2/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15817 ✓ G 15817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1640

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 S. East Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S. East Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Anna Brown

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph Brown
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 5, 1886

8. AGE: Years 58 | Months 0 | Days 27 | If less than one day: hr. ..... min.

9. Birthplace Conyville Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FURNISH FACTS

12. Name Gotlieb Turner
13. Birthplace Germany
14. Maiden Name Wilhelmina Klonk
15. Birthplace Germany

16 (a) Informant Joseph Brown
(b) Address 110 S East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 N. Paul St.

19 (a) APR 1 (Date rec'd by registrar) (b) ..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944, at 9:20 A.M.

21. I certify that I took charge of the remains described above, held an Inquisition Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 2 1944 9 A.M.
(b) Where did injury occur? 110 S. East Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanged self

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 2 1944

5818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 15818
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-11-0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 204 N. Monroe Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Leber

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Wm. F. Leber
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 22/1874

8. AGE: Years	Months	Days	If less than one day
70	2	9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Hynes
13. Birthplace Ireland

MOTHER
14. Maiden Name Sara Shields
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. City - Md.

18 (a) Funeral director STEWART & MOWEN COMPANY (W. F. WOODEN SUC.) 108 W. NORTH AVENUE
(b) Address

19 (a) APR 1 - 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1944, at 12.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1939 to April 1 1944, and that I last saw her alive on April 1 1944.

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to Cataract with	5 yrs.
Due to Cerebral arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damon P. Hayes M. D.
Address 3316 Fredonia Ave. Date signed

VS 3

5819 | BALTIMORE CITY HEALTH DEPARTMENT | G 15819

CERTIFICATE OF DEATH

92E | Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Also see that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4405 Kenwick Rd.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4405 Kenwick Road (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Frederick William MacLean

3 (b) If veteran, name war no | 3 (c) Social Security Account No. no

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lily E. MacLean | 6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) July 13 1871

8. AGE: Years 72 | Months 8 | Days 20 | If less than one day hr. 9 min.

9. Birthplace St. John New Brunswick (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Chas. MacLean
13. Birthplace Edinburgh Scotland

MOTHER
14. Maiden Name Elizebeth Donaldson
15. Birthplace St. John-New B. Can.

16 (a) Informant Mr. Ronald J. MacLean (son)
(b) Address 4405 Kenwick Road.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Apr 4/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Balto. Co. Md

18 (a) Funeral director Stewart Mort. Co.
(b) Address 108 W Monument

APR 1 - 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/44 19 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to 4/2 1944 and that I last saw h— alive on 4/2 1944.

Immediate cause of death Myocarditis | Duration Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature M A Healy M.D.
Address 1402 Park Ave Date signed 4/3/44

G 15820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 15820 Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Use only black ink. Be sure that every item is correct and complete. Answer all questions. Use "None" where necessary. If unknown, state approximate date. Do not use abbreviations. Be sure that age is correctly stated. Underlining is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1429 N. Fremont Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1429 N. Fremont Ave (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Virginia Carter

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1918

8. AGE: Years 25 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Lancaster Co. Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Lambert Carter

FATHER 13. Birthplace Richmond Co. Va

MOTHER 14. Maiden Name Marie Ball

MOTHER 15. Birthplace Richmond Co. Va.

16 (a) Informant Sylvia Carter

(b) Address 1429 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4, 1944 (month) (day) (year)

(c) Cemetery or crematory Leland Cem.

Location Lancaster Co. Va

18 (a) Funeral director Mrs. Lee A. Holland

(b) Address 1651 Druid Hill Ave

19 (a) (b) Registrar

APR 4 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/44 4:41 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24/44 to 4/1/1944 and that I last saw h[illegible] alive on 4/1/1944

Immediate cause of death Pleurisy 2d Pneumonia Duration 7 days

Due to Exposure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work

(e) Means of injury

23. Signature Jas R. Blake M. D.

Address 327 N. Central Date signed 4/4/44

15821

BALTIMORE CITY HEALTH DEPARTMENT XV G 15821
Registered No.

CERTIFICATE OF DEATH 168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Home Address
(c) City or town Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No. Glenmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Stewart

3 (b) If veteran, name war No

3 (c) Social Security Account No. 217-07-0129

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth Ann Stewart

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) Nov 28. 1886

8. AGE: Years 57 | Months 4 | Days 4 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Collector

11. Industry or business Furniture

FATHER 12. Name William Stewart

13. Birthplace Md

MOTHER 14. Maiden Name Catherine Fitzpatrick

15. Birthplace Md

16 (a) Informant Elizabeth Ann Stewart

(b) Address Glenmont Ave - Ferndale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof apr 5. 1944 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. A. Co. Md.

18 (a) Funeral director Mr. Mrs. John W. Teufel - Sons

(b) Address 801 W. Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

APR 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1944, at 7 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Communited Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April at 1 1944 6 P.M.
(b) Where did injury occur? 1100 Block N. Stricker St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? Yes
(d) Means of injury Beaten on head

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 2 1944

15822

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G 15822
Registered No.

CERTIFICATE OF DEATH 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town [illegible] (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Church Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Cwalina

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
About 56			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Mateusz Cwalina
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Szulewska
15. Birthplace Poland

16 (a) Informant Frances Cwalina
(b) Address 921 Church St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A A Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) APR 1 1944 (Date filed by registrar) (b) Hunting for Williams II Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1944, 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fracture and dislocation of the first lumbar vertebra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-10-44 at 11:20 P.M.
(b) Where did injury occur? Church St. near Eighth Street Anne Arundel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public (While at work) No.
(d) Means of injury Pedestrian struck by auto.

23. Signature J. J. Wollenweber M.D. Medical Examiner.
Date signed April 3, 1944.

15823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15823

Registered No. 61

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 57
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
a State Penna. b County
c City or town Lancaster (If outside city or town limits, write RURAL and give town)
d Street No. 246 E Walnut Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Painter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/26/1883

8. AGE: Years	Months	Days	If less than one day
60 61	11	7	hr min

9. Birthplace Lancaster Penna. (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Geo. H. Painter
13. Birthplace Lancaster Penna.

MOTHER
14. Maiden Name Margaret Fagley
15. Birthplace Lancaster Penna.

16 (a) Informant Mrs Zortch (daughter)
(b) Address 832 Kirby Lane Rd

17 (a) Burial (b) Date thereof 4-7-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Aronay
Location Lancaster, Penna.

18 (a) Funeral director James J Brundage Inc
(b) Address 1407 Eastern Ave Rd.

19 (a) APR 4 1944 Registrar
(Date received by registrar)

Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1944, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944, to April 3, 1944, and that I last saw her alive on April 3 1944.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Hypertension

Due to:

Other Conditions: Congestive failure, Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Enlarged heart, infarct of lung

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M. D.

Address Sinai Hosp. Date signed April 3 1944

G 15824

G 15824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12 B

VA-85910

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Burgundy St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kenney

3 (b) If veteran, name war

3 (c) Social Security Account No. 223-01-6581

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1912

8. AGE: Years	Months	Days	If less than one day
31	3	16 15	hr min.

9. Birthplace Va. Richmond
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James
13. Birthplace Va.

MOTHER
14. Maiden Name Viola Jackson
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4 1944 (month) (day) (year)

(c) Cemetery or crematory Richmond, Virginia
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 3221 Schroeder St.

19 (a) (Registrar)
(b) Date received by Registrar APR 4 1944
Huntington Pittsburgh PA

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 2 - 1944, at 7:35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10-1944 to 4-2-1944 and that I last saw him alive on 4-1-1944.

Immediate cause of death: Pulmonary TBc.

Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post.

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Daniel Ehrlich
Address 4940 Eastern Ave Date signed 4-3-44 M. D.

correct age is especially important. Physicians: please write the cause of death plainly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 15825
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 NORTH MONROE STREET
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NO
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 N. MONROE STREET.
(If rural give location)
(e) Citizen of foreign country? NO Yes or No
If yes, name country

3 (a) FULL NAME EDMUND NUTTER.

3 (b) If veteran, name war ----

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) June 4, 1866

8. AGE: Years 77 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business

FATHER
12. Name Samuel Nutter
13. Birthplace Phila. Penna.

MOTHER
14. Maiden Name Clara Oppelt
15. Birthplace Penna.

16 (a) Informant Mrs. Ella Nutter
(b) Address 1810 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6, 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) APR 4 - 1944 (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 3 1944 at 10. AM

21. I certify that death occurred on the date above stated; that I attended deceased from JANUARY 31. 44 to APRIL 3 19 44 and that I last saw h IM alive on APRIL 3 19 44.

Immediate cause of death	Duration
CORONARY THROMBOSIS APRIL 2	1944.
Due to CHRONIC MYOCARDITIS	1944.
Due to ARTERIOR SCLEROSIS	1944.

Other Conditions NONE
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas P Lautrec M.D.
Address 3013 ST PAUL STREET. Date signed 4/3/44

correct age is especially important. Physicians: please write in ink and make entries very legibly.

826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G 15826

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4700 Hartford Rd

(c) Hospital or institution:

Hartford Convelescent Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) St. No. 5034 Erdman Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude E. Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Calvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14, 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min
67	7	18		

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace ?

16 (a) Informant Mrs Anna G. MacPherson

(b) Address 5034 Erdman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 4, 44 (month) (day) (year)

(c) Cemetery or crematory Moreland

Location

18 (a) Funeral director Leonard Keech

(b) Address 5305 Harford Rd

Apr 1 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944, to 4-2 1944, and that I last saw h[illegible] alive on 4-1 1944.

Immediate cause of death Carcinoma of Uterus — Duration 2 years

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence — at M

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury none

23. Signature [illegible] Gordy M.D.

Address 5106 Harford Rd Date signed 4-4-44

correct age is especially important. Registrars, please

G 15827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52 B

G 15827 Registration No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Lochearn (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 W. 38th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy McElfish

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-03-9243

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Wealthy McElfish
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1884

8. AGE: Years	Months	Days	If less than one day
60	2	14	... hr. ... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business

FATHER
12. Name John McElfish
13. Birthplace Md

MOTHER
14. Maiden Name Mary Helen
15. Birthplace Md

16 (a) Informant Wealthy McElfish
(b) Address 821 W 38th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) APR 4 1944 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2 1944 at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1944 to 4-2 1944, and that I last saw h[illegible] alive on 4-2 1944

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Ca of cervix & bladder	
Due to	
Other Conditions Coronary thrombosis	

(Include pregnancy within 3 months of death)

Date of operation 3-22-44
Major findings of operation: Carcinoma of the bladder
Autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address University Hospital Date signed 4-2-44

correct age is especially important. Please write plainly.

G 15828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 15828 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 S. Arlington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S. Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura V. Jackson.

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James J. Jackson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1865

8. AGE: Years	Months	Days	If less than one day
78	4	6	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Andrew Finch.
13. Birthplace ?

MOTHER
14. Maiden Name Sallie Short
15. Birthplace ?

16 (a) Informant Lester A. Jackson.
(b) Address 132 Townsend Ave Brooklyn

17 (a) Burial (b) Date thereof Apr 3, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friendship Cem
Location Anne Arundel Co.

18 (a) Funeral director C. Hemsmeth & Son
(b) Address 3615-17 Chestnut Ave.

19 (a) APR 4 1944 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1944, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16/44 19 , to 4/2/ 1944.
and that I last saw her alive on 4/1/ 19 44.

Immediate cause of death
Cerebral hemorrhage — Duration 17 days

Due to

Due to

Other Conditions General
cerebral arterio sclerosis — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Weiler M.D.
Address 1226 Hanover St Date signed 4/3/44

correct age is especially important. Physicians: please write the cause of death plainly.

G 15829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15829 Registered No. 93E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 W 40th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 W 40th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura P. Farwell.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Oscar E. Farwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1882

8. AGE: Years 61 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Myers.
13. Birthplace Germany.

MOTHER
14. Maiden Name Hettie Beck
15. Birthplace Maryland

16 (a) Informant Mrs. George Hare
(b) Address 1117 W 40th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden
18 (a) Funeral director Edward P. Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 4 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1944 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12, 1944 to Mar 31, 1944, and that I last saw her alive on Mar 31, 1944

Immediate cause of death Mucko-pneumonia terminal — Duration 4 Days

Due to Myocarditis — 6 Mo

Due to Hypertrophic Cirrhosis — Yrs.

Other Conditions Senility.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. A. Lillie M. D.
Address 36 W Fayette St. Date signed 4/3/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

15830

G 15830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hosp. 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 73 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Montpelier St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Laura Shaw

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	Widowed

6 (b) Name of husband or wife Howard W. Shaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1856

8. AGE: Years	Months	Days	If less than one day
87	4	4 3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John H. Chandley
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lost know
15. Birthplace Baltimore Md

16 (a) Informant Mrs Mabel Timbs
(b) Address 603 Montpelier St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) APR 4 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3/44 19 . at 6 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1944 to 4/3 1944 and that I last saw her alive on 4/3 1944.

Immediate cause of death: Cardio - renal failure — Duration

Due to senility

Due to Fracture - left femur

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3/10/44 at 6 P M
(c) Where did injury occur? city (City or town) 603 Montpelier St (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No.
(e) Means of injury Fell on bedroom floor

23. Signature W. Traynor M. D.
Address Md. General Hosp. Date signed 4/3/44

24. Wellcome on S.C. but refused examination

15831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G 15831
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md. Gen. Hosp.
(c) Hospital or institution:
Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Md Gen Hosp Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2129 Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Guenther

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-2-44

8. AGE: Years	Months	Days	If less than one day
		2	hr min.

9. Birthplace Md. Gen. Hosp. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name George Guenther
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lillian Forthuber
15. Birthplace Baltimore Md

16 (a) Informant Geo. Guenther
(b) Address Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)
(c) Cemetery or crematory ~~Ulrich Funeral Home~~
Location ~~Roof Orleans St Balto~~ Lem

18 (a) Funeral director Ulrich Funeral Home
(b) Address Roof Orleans St

19 (a) APR 1 - 1944 (Date rec'd by Registrar) (b) Huntington Pikesville

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3 1944 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 1944 to 4-3 1944, and that I last saw him alive on 4-3 1944.

Immediate cause of death Atelectasis neonatorum. — Duration 2 days.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Nichols M. D.
Address Md. Gen. Hosp. Date signed 4/4/44

15832 15832 15832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a Registered No. 15832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Etmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+

(e) Length of stay in Baltimore (yrs., mos., or days) 25yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 - Etmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laurence Berry

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-7825

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	col	Married

6 (b) Name of husband or wife Ella Berry
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 9-13-1889

8. AGE: Years	Months	Days	If less than one day
55	6	19	hr. min.

9. Birthplace Montgomery Ala.
(Town, county, and state)

10. Usual Occupation Welder
11. Industry or business

FATHER
12. Name Murray Berry
13. Birthplace Ala.

MOTHER
14. Maiden Name Unk
15. Birthplace

16 (a) Informant Ella Berry.
(b) Address 1503 Etmondson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 5 44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location

18 (a) Funeral director Elmer O Wilson
(b) Address 1000 Frankfurt

19 (a) 1944 (b) (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/1944 at 8:40 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/31 1944 to 4/2 1944, and that I last saw h alive on 4/2 1944.

Immediate cause of death	Duration
Cerebral Embolism	3 days
Coronary Thrombosis	
Due to	
Due to Renal Insufficiency	3 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Jackson M.D.
Address 1000 N Eutaw Date signed 4/10/44

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

5833

JL - 86713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45 B

G 15833 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1005 Edmondson Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Angelo Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Alma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1886

8. AGE: Years	Months	Days	If less than one day
57	8	8	hr min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Lawrence Brown

13. Birthplace N. C.

MOTHER 14. Maiden Name Lucy Wiley

15. Birthplace N. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4, 1944 (Month) (Day) (Year)

(c) Cemetery or crematory Alberton Mem. Pk.

Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Holland

(b) Address 1681 Druid Hill Ave

APR 4 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1944, at 6 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-29 1944 to 3-31 1944, and that I last saw him alive on 3-31 1944.

Immediate cause of death

Carcinoma of Tongue

Due to with Metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
yrs

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Donald Boteler

Address Balto City Hosp Date signed [redacted] M. D.

15834
JL - 86606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92D

Registered No. G 15834

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Clarence Bennett (Clarance Gordon Bennett)

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Div.

6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1901

8. AGE: Years	Months	Days	If less than one day
42	5	29	hr min

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation House painter
11. Industry or business

FATHER
12. Name William E. Bennett
13. Birthplace Md. (Bradshaw)

MOTHER
14. Maiden Name Dora . Saunders
15. Birthplace Md. (Parkton)

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md

18 (a) Funeral director Wm. J. Holmes & Son
(b) Address Bel Air Md.

19 (a) Date received by local registrar Huntington Williams M.D.
APR 4 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1944, at 6'15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1944, to 4/3 1944 and that I last saw h (m) alive on 4/3 1944.

Immediate cause of death
Coronary occlusion
~~Due to~~ Arteriosclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 2 days

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Hall M. D.
Address B. C. H. Date signed 4/5/44

15835

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 B

G 15835
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 West St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria M. Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1899

8. AGE: Years	Months	Days	If less than one day hr.	min.
45	2	14		

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Kilian
13. Birthplace Md.

MOTHER
14. Maiden Name Mary L. Schnappinger
15. Birthplace Md.

16 (a) Informant Mrs. Carrie Addison
(b) Address 207 Allendale Rd.

17 (a) Burial (b) Date thereof 4/5/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Annapolis, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 4 1944

19 (a) (Date rec'd by reg.) (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944 at 7 30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/25 1944 to 4/2 1944 and that I last saw h[illegible] alive on 4/2 1944

Immediate cause of death — Duration

Due to Cardiac decompensation

Due to Mitral insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. L. Raffucci M.D.

Address Date signed 4/2/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 15836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 937

Registered No. G 15836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2236 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 2236 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIE MEDETTA SHEFTALL

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1867

8. AGE: Years 76 | Months 4 | Days 25 | If less than one day: hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles F. Forrester
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Dorcas Suzanna Merryman
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Lillie Davis
(b) Address 2236 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed by Huntington Williams, M.D. Registrar
(b) Received by registrar APR 4 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/ 1944, at 8:50AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-8 1943 to Apr 1 1944 and that I last saw h alive on April 1 1944.

Immediate cause of death: Coronary Embolism — Duration: 5 hrs
Due to: Myocarditis
Due to:
Other Conditions: Hypertension — 3 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Gark M.D.
Address Gwynn Falls Date signed April 5, 1944

correct age is especially important. Physicians, please write plainly, using ink only.

NANNIE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

15837

G 15837 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4709 Hamplth Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) — 16 4
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country /

3 (a) FULL NAME Nannie E. Adelsberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 24, 1864

8. AGE: Years	Months	Days	If less than one day
79	3	10	hr. min

9. Birthplace Emmitsburg, Md (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER 12. Name Francis Adelsberger
13. Birthplace Emmitsburg Md

MOTHER 14. Maiden Name Mary Dwyer
15. Birthplace Emmitsburg, Md.

16 (a) Informant Mrs Ruth Adelsberger
(b) Address 1938 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/1944 (month, day, year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Emmitsburg, Md.

18 (a) Funeral director John Conway & Son
(b) Address 901-03 Calhoun St

19 (a) (b) Registrar

APR 1 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1944, at 2 20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to he death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease
Carcinoma of Transverse Colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Walter [illegible] M.D. Medical Examiner
Date signed 4/3/44

15838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

85

G 15838

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 East Fort Avenue
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 East Fort Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Doda, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/10/1919

8. AGE: Years 24 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Alexander Doda,
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Anna Kuczak
15. Birthplace Baltimore, Maryland

16 (a) Informant Alexander Doda, Sr.
(b) Address 701 East Fort Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson Street

19 (a) 4 — 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1944 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18, 1939 to 4-3 1944 and that I last saw h[illegible] alive on April 2, 1944.

Immediate cause of death: Epilepsy — Duration: 10 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Wallenmeyer M.D.

Address 207 E. Fort Ave. Date signed 4-[illegible]-44

VS 250

H L Wallenmeyer M D Attended Deceased

15839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G 15839
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2026 N. Smallwood st
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 N. Smallwood st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Getzel Finkelberg

3 (b) If veteran, name w

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Zelda
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Grocer Store
11. Industry or business

FATHER
12. Name Morris Finkelberg
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mrs Fannie Cohen
(b) Address 2026 N. Smallwood st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4/44 (month) (day) (year)
(c) Cemetery or crematory Har Zion Cong Bath
Location Hamilton ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 APR 4 - 1944
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1944 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 14 1942 to 4/3 1944, and that I last saw h alive on 4/1 1944.

Immediate cause of death: Coronary occlusion — Duration: immediate

Due to: Arteriosclerosis — 9

Due to: myocardial weakness — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Levinson M. D
Address 4004 Liberty Hgts Ave Date signed 4/5/44

Correct age if apparently improper. Physicians, please write the names of deceased clearly and legibly.

VS 150

15840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15840
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2804 Clifton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Weisberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 81 | Months | Days | If less than one day: hr min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business Tailor

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Bernard Weisberg.
(b) Address 2804 Clifton Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/4/44 (month) (day) (year)
(c) Cemetery or crematory Philadelphia Pa
Location Philadelphia Pa

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) APR 7 - 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1944, at 6. A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/42 19 . to 4/5 19 44
and that I last saw h alive on 19 .

Immediate cause of death
Uraemia
Due to Cardio vascular Renal disease
Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Krunk M. D.
Address 4710 Eberly St Date signed 4/4/44

VS 150

correct age is especially important; physicians, please write plainly.

G 15841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15841 — Registered No. 36C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Easter Rolling Mills
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 N. Carey street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Glen O. Gillis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1907

8. AGE: Years	Months	Days	If less than one day
36	4	11/10	hr. min.

9. Birthplace Fredericksburg Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Emma L Dean
15. Birthplace

16 (a) Informant Emma Dean
(b) Address 1015 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. G. C.

18 (a) Funeral director Sam'l H. Chase & Son
(b) Address 638 N. Eutaw St

19 APR 4 - 1944 (Date rec'd by registrar) Hunter Jr Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1- 1944, at 9 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Meningo-vascular Syphilis

Due to

Other Conditions Subarachnoid hemorrhage
Meningioma
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 4-4-44

C 15842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. C 15842

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correctly supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 N. Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma V. King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Widowed

6 (b) Name of husband or wife Robert B. King
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 12-17-73

8. AGE: Years	Months	Days	If less than one day
70	3	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert W. Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Waverly Thomas
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. Av. & Eo

18 (a) Funeral director Sam. H. Chase Wm
(b) Address 638 N. Gilmor St

19 (a) 4-7-1944 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944, at 11.25 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Last death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral embolism
Cardiovascular - renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 2 1944

VS 151

G 15843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15843
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 37 S Ann St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Martin Leiser

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mamie Howarth
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1871

8. AGE: Years 73 | Months 1 | Days 13 | If less than one day: 12 hr min

9. Birthplace: Pittsburg, Pa (Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Joseph Leiser
13. Birthplace: Germany

MOTHER
14. Maiden Name: Theresa Mink
15. Birthplace: Switzerland

16 (a) Informant: Martin W.E. Dippel's Sons
(b) Address: 409 Gould & Ann Sts

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery or crematory: H. Redeemer
Location: Belair Rd.

18 (a) Funeral director: M. W. E. Dippel's Sons
(b) Address: 409 Gould & Ann Sts.

19 (a) APR 4 - 1944 (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1944, at 9 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 31 1944, to April 3 1944, and that I last saw h[im] alive on April 3 1944.

Immediate cause of death: Congestive heart failure.

Due to: Coronary Occlusion

Due to:

Other Conditions: Auricular fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Thomas Brennan M. D.
Address: St Joseph's Hospital Date signed 4-3-44

G 15844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15844 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 N. Bond Street (If rural give location)
(e) Citizen of what foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Chapman Chaplin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1917

8. AGE: Years	Months	Days	If less than one day
27	2	-	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Alexander Chapel
13. Birthplace Md.

MOTHER
14. Maiden Name Irene
15. Birthplace Md.

16 (a) Informant Alexander Chaplin
(b) Address 532 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Evan C. Wilson
(b) Address 1000 Bloomsbury Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1944, at 2:05 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobar, bilateral

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed March 31, 1944.

G 15845
J1 - 38039

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 G 15845 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore Citys Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 5 -14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Blake

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
65? 76 ?	?	?	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Harris
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4 5 40
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley Ave

19 (a) APR 4 - 1940
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1940, at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1938. to 3/30 1940, and that I last saw h alive on 19 .

Immediate cause of death Bronchopneumonia — Duration

Due to Hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Hall M. D.
Address B. C. H. Date signed 4/5/40

Certain age is especially important. Physicians: please write the cause of death clearly and legibly.

C 15846

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 22a

C 15846
Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 S. Pine Street
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S. Pine St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Hellen Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1941

8. AGE: Years	Months	Days	If less than one day
2	4	7	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Bernard Brayden [redacted]

13. Birthplace Md.

MOTHER 14. Maiden Name Rosie Williams

15. Birthplace South Carolina

16 (a) Informant Rs

(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/44 (month) (day) (year)

(c) Cemetery or crematory Druid Calvary

Location

18 (a) Funeral director Elroy C. Wilson

(b) Address 2000 Brandt Lazy Ave

19 (a) APR 4 — 19 (b) (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 19 44, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 19 44, to 4/1 19 44, and that I last saw h alive on 19

Immediate cause of death Multiple Intracranial

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Pinkard M. D.

Address University Hospital Date signed 4/1/44

G 15847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 D

G 15847 Registered

correct age if apparently important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2127 CAMBRIDGE ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2127 CAMBRIDGE ST.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK REHME

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ANNA REHME

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JULY 24 1874

8. AGE: Years: 69 | Months: 8 | Days: 10 | If less than one day: hr. min.

9. Birthplace: GERMANY
(Town, county, and state)

10. Usual Occupation: MACHINEST

11. Industry or business: BALTO. COPPER WORKS

FATHER
12. Name: UNKNOWN
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: ANNA MOLHMAN
15. Birthplace: GERMANY

16 (a) Informant: ANNA REHME (WIFE)
(b) Address: 2127 CAMBRIDGE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 6/44 (month) (day) (year)

(c) Cemetery or crematory: SACRED HEART
Location: GERMAN HILL ROAD

18 (a) Funeral director: Lilly and Zeiler Inc.

(b) Address: 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 3 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 20 1943, to April 3 1944, and that I last saw him alive on April 2 1944.

Immediate cause of death: Coronary occlusion — Duration: 1 day

Due to

Due to: Carcinoma of Lung — Duration: over 1 year

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature: Maria A. Ramond M. D.

Address 1705 E. Balto St. Date signed April 4, 44

G 15848

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 15848
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place.
(c) Hospital or institution:
Elmhurst Nursing Home. 77
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Samester Apts.
7010 Pk. Heights Ave.
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME
BENNETT GUMP

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1876

8. AGE: Years	Months	Days	If less than one day
67	4	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Special Officer
11. Industry or business

FATHER
12. Name Moses Gump,
13. Birthplace Germany

MOTHER
14. Maiden Name Rachel Rosenberg,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Sydney Whitehall,
(b) Address Samester Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/ 4 /44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 1902 Eutaw Place

19 (a) (Date received by registrar) (b) Registrar

APR 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd. 1944, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 - 1944, to Apr. 2 1944, and that I last saw h[illegible] alive on Apr. 2 - 1944.

Immediate cause of death — Duration

Coronary occlusion

Due to adv. arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Jacob, M. D.
Address 1700 Eutaw Place Date signed 4/3/44

VS 3

Form—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

15849 (82 W) G 15849

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 655 Idaho ST., (WARD) 2

2-FULL NAME Ellsworth Green

(a) RESIDENCE No. 655 Idaho Av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Emma Green

6 DATE OF BIRTH (month, day, and year): Aug 2 1893

7 AGE — Years: 50 — Months: 7 — Days: 28

If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cat

(b) General nature of industry, business, or establishment in which employed (or employer): Janitor

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jas. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundell Co Md

12 MAIDEN NAME OF MOTHER: Jennie Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Boston Mass.

14 Informant (Address): Lizzie Strickler 655 Idaho Av

15 Filed 1944 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 30, 1944

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1944, to March 30, 1944, that I last saw him alive on March 29, 1944, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. D. Taylor M. D.

4/4/1944 (Address) 1522 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: April 4, 4

20 UNDERTAKER: Mrs Kate R. Williams

ADDRESS 322 N Schroeder St

G 15850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 15850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert
(c) Hospital or institution: Union Memorial Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 105 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ——
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apts (If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME George Howard Duvall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Louise Barry Duvall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 Dec. 1873

8. AGE: Years 70 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, County, and state)

10. Usual Occupation Clerk
11. Industry or business

FATHER 12. Name Ridgely Duvall
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Sophia Howard
15. Birthplace Baltimore, Md.

16 (a) Informant Wife
(b) Address Ambassador Apts, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 505 N. Calvert St.

19 (a) APR 4 - 1944 (Date received by registrar) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 April 1944 at 1.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Dec. 1943 3 April 1944.
and that I last saw him alive on 3 April 1944.

Immediate cause of death Cardiac Failure

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clayton J. Van Zant M. D.
Address Union Memorial Hosp Date signed 4-3-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15851

45-322

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45D

Registered No. G 15851

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3731 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Trotta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Marie Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-29-86

8. AGE: Years	Months	Days	If less than one day
57 59	-	4	hr min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Track foreman

11. Industry or business

FATHER 12. Name Frank Trotta

13. Birthplace Italy

MOTHER 14. Maiden Name Minnie Morella

15. Birthplace Italy

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April-5-1944 (Month) (day) (year)

(c) Cemetery or crematory Mount Olivet Cemetery
Location 4430 Belair Road

18 (a) Funeral director Joseph Fiasco Inc.

(b) Address 2010 Belmont Ave

19 (a) (Date rec'd by registrar) (b) Huntington Hill (Registrar)

ADD A - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1944, at 12.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 24 1944, to April 3 1944 and that I last saw h[illegible] alive on April 3 1944

Immediate cause of death Malignant tumor of R. Mandible with Abscess & empyema of Pleural cavity & Pulmonary Embolism

Duration

Other Conditions Post-operative pneumonia

(Include pregnancy within 3 months of death)

Date of operation 3/25/44

Major findings of operation: Not done.

of autopsy: Not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul W. Rowlands

Address Johns Hopkins Hosp. Date signed 4/3/44

15852

B-87124

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160 C

Registered No. C 15852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs-23 min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 23 North Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl-Tomlinson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25-1944

8. AGE: Years	Months	Days	If less than one day
			5 hr 23 min.

9. Birthplace Baltimore-Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Winslow Tomlinson
13. Birthplace N.C.

MOTHER
14. Maiden Name Elizabeth Ryals
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Balto City Hosp

18 (a) Funeral director
(b) Address

19 (a) APR 4 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1944 to 3-25 1944 and that I last saw h er alive on 3-25 1944

Immediate cause of death: Damage to respiratory center — Duration: 5 hrs. & 23 min.
Due to Cerebral Anoxia before birth
Due to Fetal blood loss & premature seperation of placenta
Other Conditions Placenta previa centralis, maternal
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pending

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. C. Russell M.D.
Address Balto. City Hosp
Date signed 3-25-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15853
VS - 87070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160 c

G 15853
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hrs-23m
(e) Length of stay in Baltimore (yrs., mos., or days) 7hrs.23min

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Winchester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Baby Boy Price(delores)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1944

8. AGE: Years	Months	Days	If less than one day
			7 hr 23 min

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles W. Price
13. Birthplace Md.

MOTHER
14. Maiden Name Delores Wilson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave. 9am 4-3-44

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Balto City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 APR 4 - 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21- 1944 at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1944 to 3-21 1944 and that I last saw him alive on 3-21 1944

Immediate cause of death: Cerebral anoxemia — Duration

Due to Prolonged labor

Due to Contracted maternal pelvis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Russell M.D.
Address Balto City Hosp Date signed 3-21-44

VS 180

G 15854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15854 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Enson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph (Steve) Cusimano

3 (b) If veteran, name war | 3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944, at 9 50 AM

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Margaret M Hamilton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2nd 1890

8. AGE: Years	Months	Days	If less than one day
53 54	10	21	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Tailoring Proprietor

11. Industry or business

FATHER
12. Name Joseph Cusimano
13. Birthplace Italy

MOTHER
14. Maiden Name Tomasina Arena
15. Birthplace Italy

16 (a) Informant Margaret Cusimano
(b) Address 615 Enson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5th 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank J. Fitzstone
(b) Address 281 E. Baltimore St.

19 (a) APR 4 - 1944 (Date rec'd by registrar) (b) Registrar

21. I certify that I took charge of the remains described above, held an Inquestion Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Faehner M.D. Medical Examiner.
Date signed April 2 1944

VS 181

G 15855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G 15855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 842 Lynchurst St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 842 Lynchurst, (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ann Traile

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Geo C. Traile
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/23/1872

8. AGE: Years 71 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Thomas McLaughlin
13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine Croghan
15. Birthplace Ireland

16 (a) Informant Mr. Geo C. Traile
(b) Address 842 Lynchurst.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44. (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Edmondson Ave.

18 (a) Funeral director J. J. Baker Sons
(b) Address 132 S. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 4 - 1944

VS 3 Huntington Press

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 3 1944 at 8:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Apr 3 1944 and that I last saw h[illegible] alive on Apr 3 1944.

Immediate cause of death Cancer of Liver

Duration

Due to —

Due to

Other Conditions X

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: X

of autopsy: X

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify public place) While at work?
(e) Means of injury

23. Signature H. Lee Franks M. D.
Address 1340 Eutaw Place Date signed

H. LEE FRANKS

G 15856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15856 Registered No. 1214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3341 Paine St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3341 Paine St. (If rural give location)
(e) Citizen of foreign country? no, (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Snyder.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ David C. Snyder,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 14, 1854.

8. AGE: Years 89 | Months 11 | Days 19 | If less than one day: hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business —

FATHER
12. Name Nathan Beall,
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Eliza Burgee,
15. Birthplace Frederick Co. Md.

16 (a) Informant Pauline Donohue
(b) Address 4101 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-44. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn.
Location

18 (a) Funeral director Walter R. McNamee,
(b) Address 4110 Falls Road.

19 (a) 1944 (Date received by registrar) (b) Registered by Huntington Williams

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 3. 1944 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1944 to Apr 3. 1944 and that I last saw her alive on Apr 3 1944

Immediate cause of death
Chr. Myocarditis
Due to
Chr. Interstitial
Due to Nephritis

Duration
1938
1938

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown M. D.
Address 1663 W North Ave Date signed 4/4/44

G 15857

G 15857

BALTIMORE CITY HEALTH DEPARTMENT

TN. 86947

CERTIFICATE OF DEATH V186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitlas

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1845 Harford Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Isabelle Baker

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1880

8. AGE: Years	Months	Days	If less than one day
63	6	19	hr min

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At. Home

11. Industry or business

FATHER

12. Name Henry Eybes

13. Birthplace Germany

MOTHER

14. Maiden Name Mary Ludwig

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles A. Baker

(b) Address 1013 Evans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)

(c) Cemetery or crematory Most Holy Redeemer Cemetery

Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 APR 4 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150 To be approved by Medical Examiner 4/3/44

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1944, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1943 to 3-31 1944, and that I last saw h[e] alive on 3-31 1944.

Immediate cause of death: Diabetes Mellitus — Duration: ?

Due to: Diabetic Arachaemic Fracture of Femur — Duration: 8 wks

Due to: Hypertensive C.V. Disease — Duration: ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-15-44

Major findings of operation: Cort Oppf.

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 3-9-44 at ? M

(c) Where did injury occur? Balto (City or town) (County) Md (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Accidental Fall — Fell on floor way to the Bathroom.

23. Signature Donald Bickle

Address Balto City Hosp Date signed 3-31-44 M.D.

Approved, Charles J. Lubinski M.D.

G 15858

448665

BALTIMORE CITY HEALTH DEPARTMENT X 44a

CERTIFICATE OF DEATH

G 15858

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Qu. Anne's

(c) City or town Queenstown (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ruth Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	black	sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-23

8. AGE: Years	Months	Days	If less than one day
21	2	27	hr min

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Washington

13. Birthplace Md.

MOTHER 14. Maiden Name Caroline Wilson

15. Birthplace Md.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6-44 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Grasonville Md.

18 (a) Funeral director Lewis A. Henry

(b) Address Cambridge. Md.

19 (a) APR 4 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1944, at 3 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1944 to April 3 1944 and that I last saw him alive on April 3 1944.

Immediate cause of death	Duration
respiratory failure	
Due to malnutrition & weakness	
Due to granuloma inguinale	2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Huntington Williams M. D.

Address Johns Hopkins Date signed 4/4/44

G 15859 | BALTIMORE CITY HEALTH DEPARTMENT | G 15859

CERTIFICATE OF DEATH 94a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Belvedere Hotel
(c) Hospital or institution: Chas. & Chase Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County .....
(c) City or town White Plains
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Greenridge Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Frederick L. Brown

3 (b) If veteran, name war: World War #1.

3 (c) Social Security Account No. 072-09-7254

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charlotte L. Robins

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Apr 5 - 1883.

8. AGE: Years 60 | Months 11 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation Automobile Dealer

11. Industry or business

FATHER
12. Name Charles F Brown
13. Birthplace N.Y.

MOTHER
14. Maiden Name Sarah E Hunt
15. Birthplace Westfield Pa.

16 (a) Informant Charlotte L. Brown
(b) Address 24 Greenridge White Plains N.Y.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-7-44 (month) (day) (year)

(c) Cemetery or crematory Rural Cemetery
Location White Plains N.Y.

18 (a) Funeral director A Lee Oder
(b) Address 4644 York Rd

19 (a) ..... (b) ..... (Date rec'd by registrar) ..... Registrar

APR 1 - 1944 VS 15a Hunting & Williams, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 19 44, at 4:45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Hugh B. McNally M.D.
Medical Examiner.

Date signed 4/7/44

G 15860

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G 15860 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2636 Hudson St
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -
(e) Length of stay in Baltimore (yrs., mos., or days) 42 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2636 Hudson St (If rural give location)
(e) Citizen of foreign country? (~~Yes~~ or No)
If yes, name country

3 (a) FULL NAME Katarzyna Ciesla
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W.
6 (b) Name of husband or wife John Ciesla
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years 67. | Months | Days | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -

FATHER
12. Name John
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Frank Ciesla
(b) Address 2611 Fait ave
17 (a) B. (Burial, cremation, or removal) (b) Date thereof 4-10-44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dunplaff ave
18 (a) Funeral director John J Puda
(b) Address 2827 Hudson st
19 (a) 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3/44 19 at 3:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/34 19 to 4/3/44 19 and that I last saw h alive on 4/3/44 19

Immediate cause of death	Duration
Myocardial degeneration	2 yrs.
Due to Emphysema Lungs	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. [illegible] M.D.
Address 1713 E 33rd St Date signed 4/7/44

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15861 BALTIMORE CITY HEALTH DEPARTMENT G 15861
CERTIFICATE OF DEATH 1107 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1242 Hull St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK DONNELLY

3 (b) If veteran, name war: no.
3 (c) Social Security Account No. 215-01-1349

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1906
8. AGE: Years 38 | Months | Days | If less than one day hr. min

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Drain Trimmer
11. Industry or business

FATHER
12. Name Thomas Donnelly
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Welsh
15. Birthplace England

16 (a) Informant Mary Wenger
(b) Address 167 W. Monastery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 8th 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Balto Md.

18 (a) Funeral director Charles F. Dill
(b) Address 1801 E. Fort Ave

19 (a) APR 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944 at 12 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular
Due to Chronic alcoholism
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner
Date signed 4-3-44

Copy to be typewritten. Signatures, etc. must be in ink. Please write the causes of death clearly and legibly.

G 15862 Figler ✓ G 15862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Hanford Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Figlar

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Florence nee Apar 6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Aug 6 - 1916

8. AGE: Years	Months	Days	If less than one day
27	7 8	32 7	hr. min.

9. Birthplace Monessen - Pa
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Figler Sr.
13. Birthplace Pa.

MOTHER
14. Maiden Name Susanna ?
15. Birthplace Pa

16 (a) Informant Helen Apar
(b) Address 1105 Harpers Way

17 (a) Buried (b) Date thereof 4 - 4
(Burial, cremation, or removal) (month) (day)

(c) Cemetery or crematory
Location Monessen, Pa

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Hartford Ave.

19 (a) APR 4 - 1944 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 3 - 1944, at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-3-44 at 4:30 P M.
(b) Where did injury occur? 1105 Harpers Way
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury By injuries gun shot wound.

23. Signature Thomas J. Watkins M.D.
Medical Examiner
Date signed 4-4-44

15863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

462

G 15863
Registered No.

45432

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4, 10, 25
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 S. Bouldin St. (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Solari - SOLARI

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1875

8. AGE: Years 69? Months Days If less than one day hr min

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

FATHER
12. Name ? Antonio Solari
13. Birthplace Italy

MOTHER
14. Maiden Name ? Caterina Chiesa
15. Birthplace Italy

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5th/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 APR 5 1944 (b) Hunter Stevenson Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1944 at 10 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 0-8 1939 to 4/2 1944
and that I last saw him alive on 4/2 1944

Immediate cause of death: Carcinoma of Stomach — Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul McBride, M.D.
Address R - Co. H Date signed 4/3/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15864

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 15864
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4403 Garrison Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM THOMAS WHITTER

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1874

8. AGE: Years 69 | Months 11 | Days 18 | If less than one day: hr min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machinist - retired

11. Industry or business Gen'l. Elevator Co.

FATHER
12. Name Alexander C. Whitter
13. Birthplace Frederick

MOTHER
14. Maiden Name Anna E. Davis
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Minnie Whitter
(b) Address 4403 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by registrar APR 5 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Apr. 4, 1944, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Marsh 1942 to April 4 1944, and that I last saw h in alive on April 3 1944.

Immediate cause of death: Arteriosclerosis
Due to: Chronic Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 3 Yrs. / 3 Yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Sellers M. D.
Address 2267 W. Lan Date signed 4/4/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G 15865

Registered No. .....

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2203 W. Lafayette Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 6 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2203 W. Lafayette Ave. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME M. CLINTON ALBAUGH

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife M. Genevia

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 10, 1867

8. AGE: Years	Months	Days	If less than one day
77	0	22	hr ..... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Retired Foreman

11. Industry or business

FATHER — 12. Name Unknown

13. Birthplace "

MOTHER — 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs. Guy Albaugh

(b) Address 2203 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)

(c) Cemetery or crematory Lutheran Cem.

Location Shrewsbury, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 APR 5 - 1944 (Date rec'd by registrar) Hunter, Wm Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1944, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1943 to April 2 1944, and that I last saw h[illegible] alive on March 31 1944.

Immediate cause of death Arteriosclerotic Heart Disease

Due to Acute Heart Block

Due to Paralysis Agitans

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Albert J. Hunter

Address 2302 Edmondson Ave. Date signed 4/3/44

4509/15866 G 15866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Harlem Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Brooks
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: B. Brooks
6 (c) If alive, give age: 38 years
7. Birth date of deceased (mo., day, yr.): 5-8-04
8. AGE: Years: 39 Months: 10 Days: 25 If less than one day: hr. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

MOTHER / FATHER
12. Name: Henry Thomas
13. Birthplace: VA
14. Maiden Name: Trannie Jordan
15. Birthplace: VA

16 (a) Informant: Carrie Brooks
(b) Address: 1324 Harlem Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 7 1944
(c) Cemetery or crematory: Beulah Cemetery
Location: Lancaster Co. Va
18 (a) Funeral director: Mrs Laura A. Holland
(b) Address: 1631 Druid Hill Ave
19 (a) APR 5 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APR 3 1944, at 6.20 A M
21. I certify that death occurred on the date above stated; that I attended deceased from MAR 13 1944 to APR 3 1944, and that I last saw her alive on APR 3 1944.

Immediate cause of death: respiratory failure — Duration: 3 wks
Due to: blood loss
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: E Barlenght M. D.
Address: Johns Hopkins Date signed: 4/8/44

VS 180

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 15867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G 15867 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 Brevard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Brevard St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah N. Troy

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Lexington, Va (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Bayer
13. Birthplace Lexington Va

MOTHER
14. Maiden Name Mathilda Johnson
15. Birthplace Lexington Va

16 (a) Informant Lucretia A. Troy
(b) Address 1118 Brevard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1651 Druid Hill Ave

19 (a) (Date received by registrar) (b) Registrar

APR 5 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1947, to April 2 1947, and that I last saw her alive on April 2, 1947.

Immediate cause of death Carcinoma uteri

Duration: not definite

Due to

Due to

Other Conditions Broncho-pneumonia 9 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles T. Woodley M. D.
Address 861 Harlem Ave Date signed 4/4/47

V8 150

correct age is especially important. Typewrite or print plainly with pen and use ink. Do not use pencil. Be sure cause of death is clearly and legibly.

G 15868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$2 B

G 15868 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 501 E. Chase Street

(c) Hospital or institution: St. Frances Convent

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County,

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 501 E. Chase St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sister Mary Joanna Osborn C. S. P.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1859

8. AGE: Years	Months	Days	If less than one day: hr.	min.
85	10	16		

9. Birthplace Montreal Canada (town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER — 12. Name Unknown

13. Birthplace "

MOTHER — 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mother M. Teresa C. S. P.

(b) Address 501 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 1944 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cemetery

Location Frederick Road

18 (a) Funeral director Mrs. Robert Edmonds Daughter

(b) Address 1129 N. Caroline St.

19 (a) (b) (Date received by registrar) Hunting Registrar

VS 150 APR 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1944, to April 3rd 1944, and that I last saw her alive on April 3 1944.

Immediate cause of death	Duration
Cerebral Thrombosis	1 week
Due to Cerebral Arteriosclerosis	2 years
Due to	
Other Conditions Hypostatic Pneumonia	1 day

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation:

of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jos. Caulfield M. D.

Address 200 E. Lexington St Date signed April 4/44

correct age is especially important. Any person who knowingly gives false information on this certificate is guilty of a misdemeanor and subject to the penalty of the law.

G 15869

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 15869 Registered No.

CERTIFICATE OF DEATH 48a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 864 W Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 864 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ONA (ANNA) KURSVIETIS (OVA)

3 (b) If veteran, name war: O
3 (c) Social Security Account No. 215054264

4. Sex: F.
5. Color or race: White
6 (a) Single, married, widowed, or divorced: MARRIED.
6 (b) Name of husband or wife: Pius
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 7/24/1888

8. AGE: Years 55 Months 56 Days 8 If less than one day ..... hr. 29 min.

9. Birthplace Mariampolski Thuania (town, county, and state)
10. Usual Occupation Tailor — (in part)
11. Industry or business None

FATHER
12. Name Anthony.
13. Birthplace Lithuania

MOTHER
14. Maiden Name Kathrine
15. Birthplace Lithuania

16 (a) Informant Daughter. Anna.
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 5 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Baltimore Md.

18 (a) Funeral director Joseph Kesmarkes Inc.
(b) Address 442 Washington Blvd

APR 5 1944 (a) (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 3 1944, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1941, to date 19..., and that I last saw h alive on April 2 1944.

Immediate cause of death: Uremia
Cardiac failure
Pulmonary Edema
Due to: Pulmonary metastasis
Due to: Carcinoma of Cervix
Other Conditions: None.
(Include pregnancy within 3 months of death)

Duration: 2 hr. / 3 yr

Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William K. Diehl M. D.
Address 11 E. Chase St. Date signed 4/3/44

DIEHL

Correct age is especially important. If unknown, please state approximate age, and whether estimated by years or months.

G 15870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G 15870 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 W. Barre St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 W. Barre St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Sexton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Ella M. Sexton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1 - 1866

8. AGE: Years	Months	Days	If less than one day
77	8	3	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name James Sexton
13. Birthplace Ireland
14. Maiden Name Margaret Hopkins
15. Birthplace Ireland

16 (a) Informant Mrs Margaret Mc Connell
(b) Address 3512 Spaulding Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) (Date received by Registrar) (b) Registrar

APR 5 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/44 19 . at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4/44 19 to 4/4/44 19 ; and that I last saw h alive on 4/4/44 19

Immediate cause of death	Duration
Due to Hypostatic Pneumonia	2nd day
Due to Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. J. Sexton M. D.
Address 612 Edmondson Date signed 4/5/44

Hunting for [illegible]

G 15871 ✓ G 15871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48 B

Registered No. G 15871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1825 Bell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits write RURAL and give town)
(d) Street No. 1825 Bell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Cox

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Julian H. Cox

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb. 3 - 1887

8. AGE: Years 57 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name John J. Curran
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Stump
15. Birthplace Baltimore Md.

16 (a) Informant Julian H. Cox
(b) Address 1825 Bell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 16, 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cemetery
Location A.A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 (a) APR 5 - 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1944, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1944 to April 3 1944 and that I last saw h[illegible] alive on April 3 1944.

Immediate cause of death: Exhaustion — Duration: 2 days

Due to

Due to Carcinoma of Uterus — Indef.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. H. Carmichael

Address 1644 Hanover St Date signed 4/4/44

15872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G 15872 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Fielda

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Widowed

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1860

8. AGE: Years	Months	Days	If less than one day
83	8	17	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alfred Pitts
13. Birthplace Va

MOTHER
14. Maiden Name Julia ?
15. Birthplace Va

16 (a) Informant Lillie Jones
(b) Address 517 N Central Ave

17 (a) Burial (b) Date thereof 4/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Joseph G. Locke
(b) Address 1364 N. Central Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944 at 6 P M

21. I certify that death occurred on the date above stated, that I attended deceased from March 25 1944 to April 2 1944 and that I last saw her alive on April 1 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 9 days.

Due to Hypertensive Cardiovascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. G. Hayes M. D.
Address 222 N. Curo Court Date signed

15873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 15873 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2872 Kentucky Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2872 Kentucky Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK PFAFF

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-09-9581

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elisabeth Mary Pfaff

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 16, 1887

8. AGE: Years 56 | Months 8 | Days 17/16 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Paper Cutter

11. Industry or business U. S. Litho. Co.

FATHER
12. Name George Pfaff
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Miller
15. Birthplace Baltimore, Md.

16 (a) Informant Geo. T. Pfaff
(b) Address 4365 Sheldon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery or crematory First Evangelical Cem
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) APR 5 - 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1944 at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1940 to April 2 1944, and that I last saw him alive on April 2 1944.

Immediate cause of death: Carcinoma of Colon — Duration: 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac L. Denney, M.D.
Address 1111 Belair Rd. Date signed 4/4/44

G 15874

G 15874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4513 Weitzel Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County - -

City or town Baltimore - 14 (If outside city or town limits, write RURAL and give town)

(d) Street No. 4513 Weitzel Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country .....

3 (a) **FULL NAME** ETTA MARIA MILLS

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Charles O. Mills

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Dec. 3. 1872

8. AGE: Years 71 | Months 4 | Days 0 | If less than one day: hr. ..... min. .....

9. Birthplace Eastern Shore - Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER 12. Name James H. Disharoon

FATHER 13. Birthplace Salisbury Md.

MOTHER 14. Maiden Name Rebecca Brittingham

MOTHER 15. Birthplace Maryland

16 (a) Informant Mr. Charles C. Mills (Son)

(b) Address 3705 Delverne Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 3. 1944 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem. Park

Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.

(b) Address North Ave. & Broadway.

19 (a) APR 5 - 1944 Registrar

(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April. 3. 1944 at 11.55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1939 to April 3 1944. and that I last saw h[illegible] alive on April 1 1944.

Immediate cause of death: cardiac failure — Duration: 4 years

Due to hypocardia

Due to apoplexy - cerebral haemorrhage 2 hrs.

Other Conditions Chronic nephritis, arteri-sclerosis, hypertension.

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Benjamin Pushkin M. D.

Address 2338 Eutaw Pl. Date signed Apr. 4-44

G 15875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 15875
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward L. Bury

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-14

8. AGE: Years	Months	Days	If less than one day
29	5	8	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Tavern Owner

11. Industry or business

FATHER
12. Name Lawrence Bury
13. Birthplace Balto

MOTHER
14. Maiden Name Margaret Bury
15. Birthplace Balto

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 4/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John G. McGann
(b) Address 3000 E. Balto. St

19 (a) Filed (Date received by registrar) APR 5 1944 (b) Registrar Huntington Williams, M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3 — 1944, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 — 1944 to 4-3 — 1944, and that I last saw him alive on 4-3 — 1944

Immediate cause of death (a) Bilateral Bronchopneumonia — Duration

Due to aseptic purulent meningitis

Due to Brain abscess

Other Conditions chronic sinusitis

(Include pregnancy within 3 months of death)

Date of operation 3-29-44

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank L. Vanni, M. D.
Address St. Joe. Hosp Date signed 4-3-44

G 15876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944

Registered No. G 15876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give township)
(d) Street No. 3009 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Dunlap

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Helen

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr) Dec 12, 1869

8. AGE: Years	Months	Days	If less than one day
74	3	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Thomas Dunlap
13. Birthplace Penna.

MOTHER
14. Maiden Name Margaret Wilson
15. Birthplace Md

16 (a) Informant Helen S. Dunlap
(b) Address 3009 E. Baltimore St

17 (a) Burial (b) Date thereof 4/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director John A. McAfee
(b) Address 3002 E. Balto St

19 (a) (b) Registrar
(Date rec'd by Registrar)

APR 5 - 1944

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1944. 8 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed April 5 1944

G 15877

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 15877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 Harlem Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Merie M. Manthei Martha ~~Martha~~

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow MANTHEI

6 (b) Name of husband or wife Herman Manthei
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1871

8. AGE: Years	Months	Days	If less than one day
72.	9 10	21 20	hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name August Kriewald
13. Birthplace Germany

MOTHER
14. Maiden Name Louise [illegible]
15. Birthplace Germany

16 (a) Informant Mrs Helen Hamburger
(b) Address 2003 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 7/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore
18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St
19 (a) APR 5 - 1944 (Date rec'd by registrar) Huntington Tittle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1944 at 11:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1944 to Mar 31 1944, and that I last saw her alive on Mar 31 1944.

Immediate cause of death	Duration
Cerebral Embolism	
Due to	
Due to	
Other Conditions Arteriosclerotic cardiovascular disease — Femoral Phlebitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester F. Lubrinski M. D.
Address 5217 Harford Rd Date signed 4/7/44

(OVER)

VS 8

Physicians: Please write plainly, using ink. Be sure to answer all questions. Do not abbreviate. Write out full words. Be sure to give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52B

Registered No. G 15878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 S. Calhoun St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 S. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J. ENSOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1861

8. AGE: Years	Months	Days	If less than one day
82	8	8	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired Paper Hanger
11. Industry or business

FATHER
12. Name Jessie Ensor
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes Linton
15. Birthplace Maine

16 (a) Informant Mrs. Emma C. Ensor
(b) Address 303 S. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 5 - 1944 Huntington Williams, M.D. Registrar
(Filled in by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 4, 1944 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/44 19.. to 4/4 1944.
and that I last saw him alive on 4/4 1944.

Immediate cause of death. Carcinoma of bladder — Duration 6 mons.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 20 So Wilkens Ave Date signed 4/5/44 M. D.

G 15879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 15879 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5900 York Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5900 York Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH REBECCA MAGEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Alexander B. Magee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1871

8. AGE: Years	Months	Days	If less than one day
72	8	5	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Kerr
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Gardner
15. Birthplace Unknown

16 (a) Informant Mr. Ward
(b) Address 5900 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 5 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1944, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1944, to April 4 1944, and that I last saw h alive on April 4 1944.

Immediate cause of death
Asphyxia Nullata
Coma Paralysation Nephritis

Duration
1930
1940
1944
1944

Due to

Due to
Asphyxia Coma
Other Conditions Uraemia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. D. Bishop
Address 5901 Sheridan a Date signed 4/5/44

G 15880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

G 15880

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 4/2/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 4/2/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Richmond
(If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Arnold Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES L. JOHNSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	284-14-6385

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1894

8. AGE: Years	Months	Days	If less than one day
49	6	6 5	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation Deck Engineer
11. Industry or business Merchant Marine

FATHER
12. Name Charles Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Grace ?
15. Birthplace Va.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Roland Ave.

18 (a) Funeral director G. Lee Odle
(b) Address 4644 York Rd.

19 (a) (Date received by local registrar) (b) [illegible] Registrar

APR 5 1944

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH April 3, 1944, at 6:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2, 1944 to April 3, 1944, and that I last saw him alive on Apr. 3, 1944.

Immediate cause of death Nephritis & Uremia — Duration Unk.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. S. [illegible]
Address Baltimore, Md. Date signed 4/5/44 M. D.

MS-52086

G 15881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G 15881 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1436 Penna. Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 Penna. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Hayes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27 1900

8. AGE: Years	Months	Days	If less than one day
43	5	4	hr. min.

9. Birthplace Montague, Va. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Obie Hayes
13. Birthplace Essex Co. Va

MOTHER
14. Maiden Name Beadles Bowles
15. Birthplace Essex Co. Va.

16 (a) Informant Mrs Lottie Robinson
(b) Address 206 N. Amity, Apt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder Ave

19 (a) (Signature of local registrar) (b) Huntington Tildsley Registrar

APR 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1-1944, 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1944 to 4-1 1944, and that I last saw h[illegible] alive on 4-1 1944

Immediate cause of death: Cerebral Apoplexy — Duration: 1 Day
Due to: Hypertension, Renal-Cardiac
Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. F. Fletcher
Address 1725 Park Date signed 4/3/44

G 15882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15882 Registered No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 931 LINDEN Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERALD AARON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: BLACK | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-28-40

8. AGE: Years 3 | Months 9 | Days 6 | If less than one day hr min.

9. Birthplace West Va. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Willie Aaron

13. Birthplace Alabama

MOTHER 14. Maiden Name Kelsie Dodson

15. Birthplace Va.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/44 (month) (day) (year)

(c) Cemetery or crematory Location Welch, W. Va.

18 (a) Funeral director Elzey G. Wilson

(b) Address 1000 Bright Lane

19 (a) APR 5 - 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APR 4 1944 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 28 1944 to APR 4 1944, and that I last saw h/M alive on APR 4 1944

Immediate cause of death: Respiratory failure

Due to: Meningitis

Due to: Tuberculosis

Other Conditions: Miliary tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Meningitis and miliary tuberculosis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul E. Wilson M. D.

Address Johns Hopkins Hosp Date signed 4-4-44

(1)

G 15883

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15883 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 N. Carrollton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 N. Carrolton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Cottman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widowed

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/19/1878

8. AGE: Years	Months	Days	If less than one day
65	6	12	hr. min.

9. Birthplace Oriole, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Cottman
13. Birthplace Md.

MOTHER
14. Maiden Name Rosetta ?
15. Birthplace Md.

16 (a) Informant Pearl Bonner
(b) Address 918 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Elroy O. Wilson

18 (a) Funeral director
(b) Address 1000 Brantley Ave.

19 (a) 4-08-1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1944, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1944, to Mar 31 1944, and that I last saw him alive on Mar 31 1944

Immediate cause of death: Cardio-vascular Renal disease — Duration: 2

Due to

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Wheatley M. D.
Address 1230 Druid St. Date signed 4/4/44

G 15884

VO #87019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G 15884

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: Baltimore City Hosp. 4940 Eastern Avenue, Balto. Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1633 E. Fayette St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3 (a) FULL NAME John Porter

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1902

8. AGE: Years	Months	Days	If less than one day
41	5	5	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Maryland Dry Dock

11. Industry or business .....

FATHER

12. Name William Porter (d)

13. Birthplace Virginia

MOTHER

14. Maiden Name Bell White (d)

15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)

(c) Cemetery or crematory .....

Location Mt. Calvery

18 (a) Funeral director Elroy C. Wilson

(b) Address 1000 Bradley ave

19 (a) APR 5 - 1944 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1944, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1944 to 4/3 1944. and that I last saw him alive on 4/3 1944.

Immediate cause of death Pulmonary - caseous TBC — Duration ?

Due to .....

Due to .....

Other Conditions Pulmonary emboli (Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: as above

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature E. L. Serpman

Address BCH Date signed 4/4 M. D.

VS 150

15885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 15885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma F. Damm

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Henry Damm

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1874 — July 18,

8. AGE: Years	Months	Days	If less than one day
69	8	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Domestic

FATHER
12. Name (Unknown) Dowling
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Irwin E. Gardner
(b) Address 852 Ramsay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/44 (month, day, year)
(c) Cemetery Edgewood
Location Brooklyn, Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) APR 5 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1944, at 1 35 PM

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 2 1944.

G 15886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 D

G 15886 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 N. Chester ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vivian E Donaldson

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Robert E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1902

8. AGE: Years	Months	Days	If less than one day
41	9	25	16 hr. min.

9. Birthplace Florida (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew Joseph Wilson
13. Birthplace Unknown

MOTHER
14. Maiden Name Clara Hudson
15. Birthplace Unknown

16 (a) Informant Robert E Donaldson
(b) Address 414 N Chester St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 4/7/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1210 Eutaw St

19 (a) APR 5 - 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944, at 4:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Hypertension cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert E Donaldson M.D.
Medical Examiner.
Date signed April 5 1944

VS 151

6 15887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 107

Registered No. 6 15887

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland Gen'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 11
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5814 Windsormill Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Herbert Richard Speake

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	w	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1944

8. AGE: Years	Months	Days	If less than one day
—	—	12 11	hr min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Maurice E Speake
13. Birthplace Balto

MOTHER
14. Maiden Name Gladys Wells
15. Birthplace Balto

16 (a) Informant Maurice Speake
(b) Address 5814 Windsormill Md

17 (a) Buried (b) Date thereof 4/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Milburn Corp Inc
(b) Address 1219 E Fayette St

19 (a) APR 5 - 1944 (b) Lexington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 4 1944 at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 19— to 4-4 19—
and that I last saw him alive on 4-4 1944.

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Herman Watkins M. D.
Address Md. Gen. Hosp. Date signed 4-4-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 15888
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2529 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1420 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Worley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband ~~or wife~~ Samuel David Worley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7th 1860

8. AGE: Years 75 | Months 9 | Days 15 | If less than one day hr. min

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Jeremiah Collins

13. Birthplace Unknown

MOTHER 14. Maiden Name Charlotte

15. Birthplace Md.

16 (a) Informant Mrs. Edward F. Beil

(b) Address 2529 Edmondson Ave

17 (a) Burial (b) Date thereof 4/7/44
(Burial, ~~cremation or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Lorraine

Location Balto. Co. Md.

18 (a) Funeral director William Cox, Inc

(b) Address 1217 St. Paul St

19 (a) APR 5 - 1944 (b) Thomas J. Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1944, at 12:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944, to Apr 4 1944, and that I last saw her alive on Apr 4 1944

Immediate cause of death

Cardio-vascular Syphilis

Due to Chronic diabetes

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration
5 yrs

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norma U. Todd M. D.

Address 735 N. Fulton Ave Date signed 4/4/44

PHYSICIANS: PLEASE PRINT, WITH UNFADING INK. Entries must be complete and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15889

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15889 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 E. Lafayette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. yrs., mos., or days None
(e) Length of stay in Baltimore yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED
a. State Md. b. County City
c. City or town Baltimore
d. Street No. 1411 E. Lafayette Ave.
e. Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Garvey
3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Grace I. Phillips
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) July 25, 1888
8. AGE: Years 55 Months 8 Days 9 If less than one day ######## min
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Police Officer
11. Industry or business Balto: City

FATHER
12. Name Thomas Garvey
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Fannion
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Grace I. Garvey
(b) Address 1411 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) APR 5 - 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1944 at 3-40 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from March 11 1944 to April 3 1944
and that I last saw h alive on 4-3 1944

Immediate cause of death:
Duodenal Ulceration — Duration 3 days
Due to Embolism
Due to Hypertension
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town, County, State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature [illegible] M.D.
Address [illegible] Date signed 4-3-44

PHYSICIAN
Underline the cause to which death should be charged. State to nearest day.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15890

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15890
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 3/30/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 3/30/44

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Anne Arundel
(c) City or town Severn
(If outside city or town limits, write (RURAL) and give town)
(d) Street No. -
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME HENRY CHESTER SMITH
(b) If veteran, name war: World's War #1
(c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
(b) Name of husband or wife: Single
(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 11/3/1886

8. AGE: Years 57 | Months 5 | Days 1 | If less than one day: hr. min.

9. Birthplace Severn, Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business -

FATHER
12. Name Henry F. Smith
13. Birthplace Mt. Eldridge Landing A.A. Co. Md.

MOTHER
14. Maiden Name Eveline Durner
15. Birthplace Severn, Md.

16. (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17. (a) Burial
(Burial, cremation, or removal)
(b) Date thereof Apr. - 1944
(month, day, year)
(c) Cemetery or crematory Friendship Sh. yard
Location Anne Arundel Co. Md.

18. (a) Funeral director Thomas W. Higdon
(b) Address Glen Burnie, Md.

19. (a) (b)
(Signature of registrar) (Registered)
APR 5 - 1944

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH April 4, 1944 at 11:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from Mar. 30, 1944 to Apr. 4, 1944, and that I last saw him alive on Apr. 4, 1944

Immediate cause of death: Medical shock secondary to pneumococcic meningitis & pneumococcic lobar pneumonia

Duration: Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/31 & 4/1/44-Spinal punctures
Major findings of operation: Meningitis

of autopsy: None done

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury
(f) Signature [illegible] M.D.
Address Baltimore, Md. Date signed 4/4/44

Va-14401

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

45022

G 15891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15891 Registered No.

100a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot
(c) City or town St. Michaels (If not in city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Lillie V. Thomas
3. (b) If veteran, name war
3. (c) Social Security Account No.

4. Sex Female
5. Color or race Black
6. (a) Single, married, widowed, or divorced. Married
6. (b) Name of husband or wife James
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 98
8. AGE: Years 45 Months 2 Days 9 If less than one day hr min
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Murray H. Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. Smith
15. Birthplace Md

16. (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/7/44
(c) Cemetery or crematory St Michaels Maryland
Location John A Mitchell Hearse
18. (a) Funeral director 190 Eastern Ave
(b) Address Huntington Ave
19. APR 5 - 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1944 at 6 12 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 29 1944 to April 4 1944 and that I last saw h[illegible] alive on April 4 1944

Immediate cause of death: acute pulmonary edema — Duration: 15 min
Due to: Diodrast
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work)
(e) Means of injury
23. Signature H Cartwright M.D.
Address Johns Hopkins Date signed 4/5/44

Autopsy Graham MD to be checked by Dr Graham - medical examiner.

G 15892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15892 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED
a State Md b County Anne Arundel
c City or town Pasadena (If outside city limits write RURAL and give town)
d Street No. (If rural give location)
e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Lillie Mae Shaw
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced. child
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 1940
8 AGE: Years 3 Months 11 Days 10 If less than one day: hr. - min
9. Birthplace Glenburnie, Md (Town, county and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name James Shaw
13. Birthplace Md

MOTHER
14. Maiden Name Pearl Farrow
15. Birthplace Md

16 (a) Informant R Kaye
(b) Address Sydenham Hosp

17 (a) (Burial, cremation, or removal)
(b) Date thereof (Month, day, year)
(c) Cemetery or crematory
Location
3/5/44
Mt Auburn Cem

18 (a) Funeral director Mrs Katie R Williams
(b) Address 3224 Sahlender St

19 (a) (Signature of registrar)
Hamilton for Williams M.D.
(b)

PR 5-1944
VS-100

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3/44 1944 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1944 to 3/3/ 1944 and that I last saw h cr alive on 3/3/ 1944

Immediate cause of death Resp failure — Duration 4 days

Due to Uremia

Due to Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
a Accident, suicide, or homicide
b Date of occurrence at M
c Where did injury occur? (City or town) (County) (State)
d Did injury occur about home, on farm, industrial place, in public place? While at work?
e Means of injury
23. Signature Rosen Kaye
Address Sydenham Date signed 3/3/44

15893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G 15893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Lane
(c) Hospital or institution: Mt Hanna Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Glyndon (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Cora D. Cassard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	White	Widowed

6 (b) Name of husband or wife Reuben Cassard.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1862

8. AGE: Years	Months	Days	If less than one day
77	1	16	17 hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)
10. Usual Occupation Home.
11. Industry or business

FATHER
12. Name Henry D. DeVries
13. Birthplace Md.

MOTHER
14. Maiden Name Anne C. Hissey
15. Birthplace Md.

16 (a) Informant DeVries Cassard
(b) Address 2502 Evelyn Ave. Balto Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. View Cemetery
Location Howard County, Md.

18 (a) Funeral director C. Harry Zahn
(b) Address Reisterstown, Md.

19 (a) APR 6 - 1944 (Date rec'd by registrar) (b) Clinton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1944, at 3.15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1943, to April 5 1944 and that I last saw h[illegible] alive on April 4 1944.

Immediate cause of death	Duration
Coronary Thrombosis	4 mos.
Due to Hypertension & Arteriosclerosis	1 mon.
Due to [illegible]	2 wks.
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard L. Stoll M. D.
Address 735 Eutaw St. Date signed April 7 1944

VS 3

G 15894

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15894 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W Old Town Lane
(c) Hospital or institution: 127-13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Whiteford (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Mo

3 (a) FULL NAME Sophia K noop
3 (b) If veteran, name war W
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Edward
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 30 1865
8. AGE: Years 78 Months 6 Days If less than one day hr min
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Albert
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Carl E Knoop
(b) Address Whiteford Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-44 (month, day, year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Wilson Corp Inc
(b) Address 1219 N Pond St
APR 6 - 1944 (c) Signature and title Walter Williams Funeral Director

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944, at 6 45 M
21. I certify that death occurred on the date above stated, that I attended deceased from March 27, 1944, to April 6, 1944, and that I last saw her alive on April 4 1944

Immediate cause of death (Enter only one cause per line for (a), (b), and (c).)

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address Date signed M. D.
4-7-44

450759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15895
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No ~~Johns Hopkins Hospital~~ 1631 Garrett Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilmer Davis
3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Helen
6 (c) If alive, give age: 45 years
7. Birth date of deceased mo., day, yr: 3-11-97
8. AGE: Years: 47 Months: 0 Days: 24 If less than one day: hr min
9. Birthplace: Md (Town, county, and state)
10. Usual Occupation: Painter
11. Industry or business: J.H. Hosp
MOTHER | FATHER
12. Name: Patrick Davis
13. Birthplace: Md
14. Maiden Name: Mary Silk
15. Birthplace: Ireland
16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 4/6/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U.S. National
Location Baltimore Md.
18 (a) Funeral director: William Cook Inc
(b) Address 217 W. Pratt St
19 (a) APR 6 - 1944 (Date rec'd by registrar) Huntington Indiana (Registrar)
8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 5 1944, at 405 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Mar 9 1944, to Apr 5 1944, and that I last saw him alive on Apr 5 1944.

Immediate cause of death	Duration
Pulmonary tuberculosis	
Due to	
Due to	
Other Conditions: mod anemia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one)
(e) Means of injury
23. Signature John R. Birmingham JHH
Address Date signed 4/5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 15896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 D

G 15896
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 S. Dallas Street (If rural give location)
(e) Citizen of foreign country? Yes or No; If yes, name country

3 (a) FULL NAME Herman Wenduck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day hr.	min.
69	11	18		

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name [illegible]
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Edward Smoke
(b) Address 705 S. Dallas

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [illegible]

18 (a) Funeral director William [illegible]
(b) Address [illegible]

19 (a) APR 6 - 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 44 at 11:55 A. M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic Myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

21 Signature Robert Lee Graham M.D.
Medical Examiner
Date signed April 5, 1944

VS 151

5897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 15897
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Aisquith St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

9-9

3 (a) FULL NAME Pauline Gubrick

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1889

8. AGE: Years 65 | Months 0 | Days 6 | If less than one day: hr. 1 min. 79

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation housewife
11. Industry or business

FATHER 12. Name Kinsey
13. Birthplace Maryland

MOTHER 14. Maiden Name Maryland
15. Birthplace "

16 (a) Informant Louise Kraat
(b) Address 1911 Lansing Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Finksburg Md Carroll Co

18 (a) Funeral director Tillman Cook Inc
(b) Address 1217 E Fayette St

19 APR 6 - 1944 (Date rec'd by registrar) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 5 1944, at 6:06 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1944 to 4/4 1944, and that I last saw her alive on 4/4 1944.

Immediate cause of death: Myocarditis — Duration: 2 mo.
Due to: Diabetes Mellitus — 3 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 1279 William St Date signed 4/5/44

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G 15898 ✓ G 15898

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Cambria
(b) Street address 102 Cambridge
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Cambria
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Cambridge St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gabriel Byas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER / FATHER

12. Name unknown

13. Birthplace unknown

14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant R. Sa. Williams

(b) Address 102 Cambridge St

17 (a) (Burial, cremation, or removal) (b) Date thereof 4 6 44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co.

18 (a) Funeral director Walter B. Spencer

(b) Address 139 W Hamburg St

19 (a) APR 6 1944 (Date received by Registrar) (b) Registrar

Pleasing for Williams, Inf.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19.... at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 19 44, to April 3, 1944, and that I last saw him alive on April 3 19 44

Immediate cause of death — Duration

Coronary occlusion

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel Scalia M. D.

Address 203 [illegible] Date signed

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

5899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 15899
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert St.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hurley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/28/44

8. AGE: Years	Months	Days	If less than one day
			1 hr min.

9. Birthplace Mercy Hosp. Balto, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Hurley.
13. Birthplace Bristol Va.

MOTHER
14. Maiden Name Irene Phillippi
15. Birthplace Mt. City, Penn.

16 (a) Informant Irene Hurley
(b) Address 1628 Eutaw Place.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 5 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) APR 6 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

0848

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1944 at 7 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1944 to 3/28 1944 and that I last saw him alive on 3/28 1944.

Immediate cause of death

Cardio-Resp. Failure

Due to Prematurity

Due to Birth.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. R. Englis M. D.
Address Mercy Hosp Date signed 3/28/44

15900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 15900

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 101 S. Caton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-7

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.; (b) County

(c) City or town Baltimore.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 101 S. Caton Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lena Marsh.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married.

6 (b) Name of husband ~~or wife~~ Harry T. Marsh.

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) January 21-1893.

8. AGE: Years	Months	Days	If less than one day
51	2	14	hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Housewife,

11. Industry or business At home.

FATHER

12. Name Unknown.

13. Birthplace Germany.

MOTHER

14. Maiden Name Unknown.

15. Birthplace Germany.

16 (a) Informant Mrs. Antony Mizia.

(b) Address 707 S. Linwood Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof April-6-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.

(b) Address 505 N. Monroe St.

19 (a) APR 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April, 4th; 1944; at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944 to 4/4 1944 and that I last saw h[er] alive on 4/4 1944.

Immediate cause of death. Bronchial Pneumonia

Duration 25 days

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr. Huntington Williams

Address 336 Cathedral St. Date signed 4/5/44.

VS 150

G 15901

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G 15901
Registered No.

State File No. 57202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Pearl St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tinch Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1890

8. AGE: Years	Months	Days	If less than one day
53	10	1	hr min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Epsteins

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 154 APR 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1944 at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1944 to 4/2 1944 and that I last saw alive on 4/2 1944

Immediate cause of death
T.B.C. Pneumonia
Due to consecutive contracted carnify
Due to M. Tuberculosis Laryngis

Other Conditions
(Include pregnancy within 3 months of death)

Duration 10 d.

Date of operation
Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Jergman M.D.
Address 13 E 14 Date signed 4/5

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 15902 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correctness. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. Co.
(c) City or town Ferndale. (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vincent Swikoski
3 (b) If veteran, name war
3 (c) Social Security Account No 217-03-3859

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1879
8. AGE: Years 65 | Months | Days | If less than one day: hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tailor.
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Joseph Miller
(b) Address 24 Parkin St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md
18 (a) Funeral director Joseph Kaminska Jr.
(b) Address 6 N. Wash Blvd
19 (a) (Date rec'd by registrar) (b) Registrar

APR 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1944, at 7:20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1944, to 4-4 1944, and that I last saw h[illegible] alive on 4-4 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4-5 hours
Due to: Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Y. Bird M.D. M. D.
Address University Hosp Date signed 4-4-44

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G 15903 G 15903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Eutaw
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Carnevale

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 6 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) APR 6 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1944 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1943 to 4/4 1944, and that I last saw h alive on 4/4 1944.

Immediate cause of death
Acute Pulmonary Edema — Duration 1 da
Due to Chronic Myocarditis
Due to Cirrhosis of Liver — 5 mos

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph H. Lankcastis M. D.
Address 679 Washington Blvd Date signed 4/5/44

G 15904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 15904 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1242 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1242 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Richard Keffer, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1944

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name James Richard Keffer, Sr.
13. Birthplace Connellsville, Pa.

MOTHER 14. Maiden Name Emma A. Borman
15. Birthplace Balto., Md.

16 (a) Informant James R. Keffer, Sr.
(b) Address 1242 S. Charles St. (Balto.)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem. Location G. L. Co., Md.

18 (a) Funeral director G. Bernard Evans
(b) Address 1700-02 S. Charles St. (30)

19 (a) Filed APR 6 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1944 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2-1944 to 4-5-1944, and that I last saw him alive on 4-5-1944.

Immediate cause of death

Prematurity (7½ Months)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Calvert M. D.
Address 1014 S. Charles St signed 4-6-44

15905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

G 15905
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Walnut Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederic Berkenkemper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alma Berkenkemper

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1894

8. AGE: Years 49 | Months 6 7 | Days 6 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Paperhanger

11. Industry or business

FATHER
12. Name Frederick Berkenkemper
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea
15. Birthplace Germany

16 (a) Informant Alma Berkenkemper
(b) Address 902 Walnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7th (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Rural

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004 E. Oliver St

19 APR 6 - 1944 (Date rec'd by Registrar) (Huntington Williams M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1944, at 1:15 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fentam M.D. (Medical Examiner)
Date signed April 7 1944

correct age is especially important. Physicians, please

VS 151

15906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

Registered No. G 15906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2630 Miles ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Chester A. Alder

3 (b) If veteran, name war	3 (c) Social Security Account No.
1st W. W.	220-03-0590

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) May 1889

8. AGE: Years	Months	Days	If less than one day
54	11		hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Aberdeen Proving Ground

FATHER
12. Name Charles A. Alder
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary M. Stevens
15. Birthplace Maryland

16 (a) Informant Charles A. Alder
(b) Address 4306 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7, 1944 (month) (day) (year)
(c) Cemetery or crematory New National
Location Frederick Road

18 (a) Funeral director Ehrenwerth & Donovan
(b) Address 3615-17 Eastern Ave

APR 6 - 1944 (Date rec'd by registrar)
(b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4-1944, at 9 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema.

Due to Acute Congestive Heart Failure

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 4-4-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15Ha Registered No. G 15907

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calhoun & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life 27 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Govans P. O. (If outside city or town limits, write RURAL and give town)

(d) Street No. Bellona & Haddon Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Madelina E. Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	married

6 (b) Name of husband or wife H. Haviland Roberts

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) July 1, 1916

8. AGE: Years	Months	Days	If less than one day
27	9	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home wife.

11. Industry or business Home.

MOTHER / FATHER

12. Name Edmund A. Leidenroth.

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Sarah Flueharty

15. Birthplace Baltimore Md

16 (a) Informant H. Haviland Roberts.

(b) Address Bellona & Haddon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tipperary Sons

(b) Address Lutz. Md.

19 (a) Date rec'd by registrar APR 8 1944 (b) Registrar Huntington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23rd 1943 to April 4 1944, and that I last saw her alive on April 4 1944.

Immediate cause of death: Cerebral abscess

Due to osteomyelitis

Due to frontal sinusitis (ova)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Pus & meningeal osteomyelitis frontal sinus

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert Z. Berry M D

Address Mercy Hospital Date signed 4/7/44

G 15908 ✓ G 15908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 Whitelock St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 1
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Whitelock St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillie Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 54 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Solomon Block
13. Birthplace Russia

MOTHER — 14. Maiden Name Fanzie
15. Birthplace Russia

16 (a) Informant D. Herbert Harris
(b) Address 2511 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-44 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd.
Location Hebrew Y. M. A. R. Asso

18 (a) Funeral director Jos. Levin Sons
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) APR 6 - 1944 (b) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5-1944 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1943, to 4-5 1944, and that I last saw h.. alive on 4-4 1944.

Immediate cause of death: Cor cord vascular disease
Hypertension, Arteriosclerosis, Dia. Mellitus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Edmund Levin
Address 3400 Kilox Rd
Date signed 4/5/44 (M) (D)

G 15909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15909 Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 Bruce st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Bruce st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Willis Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 5-4-1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66	11	—		

9. Birthplace A. A. County Md (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mary Williams

(b) Address 634 Bruce st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 8 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director Williams & Jackson

(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Registrar

APR 6 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 44, at 11½ p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1944, to 4-4 1944, and that I last saw him alive on 4-4-44.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days
Due to Hypertensive Cardiac disease.	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. N. Pipkin

Address 1536 W. Fayette St Date signed 4-5 44 M. D.

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 15910 Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Norfolk (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Gold ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Sophia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 84 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Zelic
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Harry Gold
(b) Address 3525 Lucille Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Philadelphia & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) APR 6 - 1944 (Date received by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-44 19 . at 12 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 19 44 to 4/5 19 44, and that I last saw him alive on 4/5 19 44.

Immediate cause of death acute Bronchial Pneumonia

Due to Chronic myocarditis

Due to Hypertension Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Grumet M. D.
Address 1111 Lee W Date signed 4/6/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G 15911

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring
(c) Hospital or institution:
Hebrew Home for Aged & Infirm 2717

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. Belvedere & Greenspring (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Kramer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Isaac
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hebrew Home
(b) Address

17 (a) 4-6-44 (Burial, cremation, or removal) (b) Date thereof Burial (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date received by registrar) (b) (Registrar)

APR 6 - 1944

vs 21

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21/1943 to 4/6/1944, and that I last saw her alive on 6/5/1941.

Immediate cause of death (a) Cardiovascular disease
Hypertension, Arteriosclerosis
Diabetes Mellitus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Levin

Address Levindale Date signed 4/6/44 M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C 15912

15912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 N. Curley St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 521 N. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Freburger
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Capt. Henry J.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 8-1870

8. AGE: Years 73 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Timothy O'Connell
13. Birthplace Ireland.

MOTHER
14. Maiden Name Dont. know
15. Birthplace Ireland

16 (a) Informant Miss. Valeria Mitchen
(b) Address 521 N. Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Lath. Ch. Frederick Rd
Location
18 (a) Funeral director John A. Hogan
(b) Address 3000 E. Balto St.

19 (a) (Date rec'd by registrar) (b) (Registrar)

APR 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/44 19 , at M

21. I certify that death occurred on the date above stated that I attended deceased from March 10 1944 to April 6 1944, and that I last saw her alive on April 4 1944.

Immediate cause of death Myocardial Insufficiency

Due to

Due to

Other Conditions Arterio sclerosis, Hypertension, Myocarditis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)
(e) Means of injury

23. Signature John A. Johnson, M.D.
Address 337 S. Charles St. Date signed 4/6/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15913

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 15913 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 513 N. Paca Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 513 N. Paca Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gerhard P. Helmers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cathern D. Helmers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24-1860

8. **AGE:** Years 83 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER 12. Name John Gerhard Helmers

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Dill

15. Birthplace Germany

16 (a) Informant Gerhard P. Helmers

(b) Address 932 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7-1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) APR 6 - 1944 (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 4- 1944, at 5:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1944 to April 4 1944 and that I last saw h[illegible] alive on 4-4-1944.

Immediate cause of death Acute Heart Failure — Duration 1 day

Due to Chronic Myocarditis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury —

23. **Signature** Lowes W. Johnson M. D.

Address 916 Medical Arts Bldg. Date signed 4/6/44

VS 150

G 15914

G 15914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12 B

File #85973

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 29 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 E. Chase St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Juanita Poole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1926

8. AGE: Years	Months	Days	If less than one day
17	10	1	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Roosevelt Poole
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ida Mae Griner (d)
15. Birthplace Georgia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1442 E. Preston St

19 (a) APR 6 1944 (b) Registrar
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1944, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1944 to 4/3 1944, and that I last saw h_ alive on 4/3 1944

Immediate cause of death Lobar T.B.C. pneumonia — Duration ?

Due to

Due to

Other Conditions Mural Thrombi, L. ventricle
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sexman M.D.
Address 13 CH Date signed 4/4

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G 15915
Registered No.

-87240

Physicians: please write the causes of death clearly and legibly. Please see that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs, 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Hull St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Wells (Mary)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Newborn
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1944
8. AGE: Years | Months | Days | If less than one day: 1½ hrs min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Wells
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 4-5-44 9 am (month) (day) (year)
(c) Cemetery or crematory Balto City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

APR 6 - 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2 1944, at 6:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 1944, to 4-2 1944, and that I last saw her alive on 4-2 1944.

Immediate cause of death	Duration
Congenital Atelectasis	1½ hrs.
Due to Prematurity	
Due to	
Other Conditions *	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Hunsicker M.D.
Address Balto. City Hosp. Date signed 4-2-44

G 15916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 15916 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 S. Smallwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 S. Smallwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert E. Thompson
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-03-8740
4. Sex M.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife (Watkins) Blanche S.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr. 23, 1896
8. AGE: Years 48 Months 11 Days 11 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Retired 5 yrs.
FATHER 12. Name John Thompson
13. Birthplace Md.
MOTHER 14. Maiden Name Amelia Gordon
15. Birthplace Md.
16 (a) Informant Mrs. Blanche S. Thompson
(b) Address 332 S. Smallwood St.
17. Burial (Burial, cremation, or removal) (b) Date thereof Apr. 8/44. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Ave.
18 (a) Funeral director Harry H. Little
(b) Address 4101 Edmondson Ave.
19 (a) (b) Registrar
APR 6 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/44 19 . at M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to 4/4/ 1944, and that I last saw him alive on 4/4/ 1944.
Immediate cause of death Carcinoma Thrombosis Arteriosclerosis Myocarditis.
Due to
Due to
Other Conditions Pulmonary Edema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert C. Mitch M. D.
Address 2151 Walbrook Ave. Date signed 4/8/44

G 15917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 15917 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 Woodington Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 & 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Woodington Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline Moore Gardner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Allyn A. Gardner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1877

8. AGE: Years 66 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Thomas Moore
13. Birthplace Montreal Canada

MOTHER
14. Maiden Name Mary A. Welch
15. Birthplace New Brentford, Kent, England

16 (a) Informant Allyn A. Gardner
(b) Address 617 Woodington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 7/44 (Month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Road

18 (a) Funeral director Harry A. Keefe
(b) Address 4401 Edmondson Ave

19 (a) (Date received by registrar) (b) Registrar

APR 6 - 1944

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3/44 19 at 9.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943 to April 3 1944, and that I last saw him alive on April 3 1944.

Immediate cause of death: ~~Primary carcinoma of breast~~ Senile debility

Due to Primary carcinoma of breast.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 1943

Major findings of operation: Carcinoma of breast.

Autopsy:

Duration: 3 mos. / 8 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo E. Wells. M. D.
Address 4100 Edmondson Ave Date signed 4/5/44

Please write clearly with pen and ink. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G 15918

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15918 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2228 Eagle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Eagle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida F. Kuester

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	married

6 (b) Name of husband or wife Chas. H. Kuester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1887

8. AGE: Years	Months	Days	If less than one day
56	10	4	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation H. W
11. Industry or business

FATHER
12. Name Geo. Reahl
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary —
15. Birthplace Balto. Md

16 (a) Informant Charles H. Kuester
(b) Address 2228 Eagle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Mitchell
(b) Address 4101 Edmondson Ave

19 (a) (b) Registrar
(Date rec'd by reg'l reg.)
APR 6 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3/44 19 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased fr[illegible] 2/1 19[illegible] to 4/3 19[illegible] and that I last [illegible] alive on 19

Immediate cause of death: arteriosclerotic cardio vascular disease — Duration: 3 mos

Due to

Due to

Other Conditions Bronchopneumonia — Duration: 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2036 Wilkins ave Date signed 4/5/44

6 Dau. 15919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 15919 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Chilton Street, 1829
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 Chilton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Abbott

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-03 8905

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna C nee Dennisch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-3-73

8. AGE: Years	Months	Days	If less than one day
70	6	1	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Night Operator

11. Industry or business Homeward Apts

FATHER
12. Name George A. Abbott
13. Birthplace Md

MOTHER
14. Maiden Name Clementine Berger
15. Birthplace Md

16 (a) Informant Mrs Harry C. Abbott
(b) Address 1829 Chilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Harry H. Witzke
(b) Address 4201 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4-44 at 8:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weidert M.D.
Medical Examiner.
Date signed 4-5-44

VS 151

G 15920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 15920 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G 15921 G 15921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 46F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Keyworth Ave,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Keyworth Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Domenico Barranco

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maria Alcarese

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1884

8. AGE: Years 59 Months 8 Days 26 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Owner

FATHER
12. Name Salvatore Barranco
13. Birthplace Italy

MOTHER
14. Maiden Name Felicia Barranco
15. Birthplace Italy

16 (a) Informant Felicia Gloriosa
(b) Address 2910 Keyworth ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore st

19 (a) APR 6 - 1944 (Date received by registrar) (b) Huntington Williamsport W. Va.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/ 1944 at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to April 5 1944, and that I last saw him alive on April 2 1944.

Immediate cause of death Carcinoma of Liver — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Barranco M.D.
Address 436 E Fort Ave Date signed 4/5/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G 15922 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore Maryland

(c) Hospital or institution: University Hospital 2-1-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 226 S. Fremont Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 29 1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
48	7	7		

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Band C. R. R.

FATHER 12. Name Thomas Smith

13. Birthplace Accomac Virginia

MOTHER 14. Maiden Name Mamie Jeolee

15. Birthplace Accomac Virginia

16 (a) Informant Lula Bailey Sister

(b) Address 1542 N Hilleker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8, 1944 (month) (day) (year)

(c) Cemetery or crematory Arlington Memorial Park

Location Baltimore County Md

18 (a) Funeral director Joseph A. Lively

(b) Address 408 North Mount Street

19 (a) APR 6 - 1944 (Date rec'd by registrar) (b) Burial Permit No. 4 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1944 at 3:05 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed April 5, 1944.

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G 15923

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 3/25/44
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 McDonough St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Henry Carey

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Mary Mills
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1897

8. AGE: Years	Months	Days	If less than one day
51	2	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer, Camp Holabird
11. Industry or business Nov. 1943

FATHER
12. Name Thomas Carey
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Clara Colbert
15. Birthplace Baltimore, Md.

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location

18 (a) Funeral director Mr. Robert G. Elliott & Daughter
(b) Address 129 N. Caroline St.

19 (a) APR 6 - 1944 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1944 at 9:06 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25, 1944 to Apr. 4, 1944, and that I last saw him alive on Apr. 4, 1944.

Immediate cause of death 1. Bilateral pneumonia, stage of late gray hepatization; 2. Subacute bacterial endocarditis — Duration: Unk

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(d) Means of injury (Specify whether home, farm, industrial place)

23. Signature [signature]
Address Baltimore, Md. Date signed 4/5/44 M. D.

Va-14390

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G 15924
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4902 Wright avenue
(c) Hospital or institution: Armistead Gardens
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) St. No. 4902 Wright Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. OLIFF, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife Child

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John H. Oliff
13. Birthplace Onley, Va.

MOTHER
14. Maiden Name Zella Waddell
15. Birthplace Ohio

16 (a) Informant Zella Oliff
(b) Address 4902 Wright Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8 1944 (month) (day) (year)

(c) Cemetery or crematory
Location Oakland, Kentucky

18 (a) Funeral director Wendell Hepp
(b) Address 312 S. Highland Ave

19 (a) (b)
Date rec'd by Registrar PR 6 - 1944 Funeral Director for Williams & Hepp
VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1944, at 10:30 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pneumonia, lobular

Due to primary

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. A. Wallenmeyer M.D.
Medical Examiner
Date signed 4-6-44

G 15925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15925 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Poplar Grove St
(c) Hospital or institution:
16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Hoyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Martin J. Hoyle
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 5, 1873

8. AGE: Years	Months	Days	If less than one day
70	9	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business at home

FATHER
12. Name Robert E. Tasco
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Alice J. Allen
15. Birthplace Washington D.C.

16 (a) Informant Mr Martin J. Hoyle
(b) Address 1211 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4200 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901 N. Bloadway

19 (a) APR 6 1944 Registrar Hunter to Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1944, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1942 to April 5 1944 and that I last saw h[illegible] alive on April 4 1944.

Immediate cause of death Coronary occlusion
Due to Coronary disease
Due to
Other Conditions Arterio sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James V. Rosenberger M. D.
Address 721 Mulberry Date signed 4/6/44

correct age is especially important. Physicians: please write clearly cause or causes of death clearly and legibly.

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15926 /93D

G 15926 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 31 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charlotte Dillon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John Dillard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant William J. Barnes

(b) Address 31 N Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4th (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Gardy

18 (a) Funeral director Robert E. Williams

(b) Address 1315 Madison Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 191 8-1944 Huntington Williams H.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1944, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Hypertensive cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed April 4, 1944

15927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 15923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Loraetta Ave.
(c) Hospital or institution:
20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Loraetta Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Miller Cleary

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Anna Agnes Kirlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1890

8. AGE: Years 44 | Months 11 | Days 3 | If less than one day: hr. min.

9. Birthplace Ireland. (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Md. Gas. Co.

FATHER
12. Name Robert L. Cleary
13. Birthplace Ireland.

MOTHER
14. Maiden Name Julia Dearing
15. Birthplace Ireland.

16 (a) Informant Family
(b) Address 2401 Loraetta Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 4-8-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director James L. McCarthy
(b) Address 130 E. Fort Ave.

19 (a) [illegible] (Name of informant) Huntington Williams Jr.

APR 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1944, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1943 to April 3 1944, and that I last saw h[illegible] alive on April 3 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 10½ Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Kirchner M.D.
Address 2302 Eutaw Pl. Date signed 4/4/44

correct age is especially important. Physician: please write the causes of death clearly and legibly.

G 15928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 7/31a

G 15928 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N.Decker Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

7-1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 514 N.Decker Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Esposito

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch.31,1860

8. AGE: Years	Months	Days	If less than one day
84		4	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Ulrick Trautner
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Seibert
15. Birthplace Germany

16 (a) Informant Mrs.Emma Freburger
(b) Address 514 N.Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/44 (month) (day) (year)
(c) Cemetery or crematory St. Mathews
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) (Received by registrar) (b) Huntington Williams Registrar

APR 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1944 at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1944 to 4/4 1944 and that I last saw h[illegible] alive on 4/3 1944

Immediate cause of death: Uremia due to chronic nephritis of several years duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: ?

4/11/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex L. Sikorsky, M.D.
Address 1939 N. Eliagh Date signed 4/5/44

correct age is especially important. Physicians, please write

C 15929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 15929 Registered No. 46

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 740 N. PATTERSON PK AVE (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jacob Stauch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	(Separated)

6 (b) Name of husband or wife Elizabeth Dorman Stauch
6 (c) If living, give age 48

7. Birth date of deceased (mo., day, yr.) Feb 26 1896

8. AGE: Years	Months	Days	If less than one day
68	1	9	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Brick Layer
11. Industry or business

FATHER
12. Name Adam Stauch
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Jacob Stauch
(b) Address 444 E Lemmon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 8 44 (month) (day) (year)
(c) Cemetery or crematory Mt Lawn
Location Donnell St

18 (a) Funeral director Clarence F Kellerman
(b) Address 1639 N Broadway

19 (a) (Date rec'd APR 6 1944) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5 1944. at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1944. to April 5 1944. and that I last saw him alive on 4-5 1944.

Immediate cause of death Gastric Carcinoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-18-44

Major findings of operation: Large Gastric Operation & abdom. metastases

If autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Steven Hatch M. D.
Address Church Home Hospital Date signed 4-5-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 15930
Registered No.

15-7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3323 Alto Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3325 Alto Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LULU VIRGINIA TAYLOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Walter Ford Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1851

8. AGE: Years	Months	Days	If less than one day
82	9	9	hr min

9. Birthplace Raleigh, N. C. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas R. Fentress
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Jane Johnson
15. Birthplace England

16 (a) Informant Mrs. Joseph R. Wilson, Jr.
(b) Address 3325 Alto Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 5, 1944, at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1939, to Apr. 5 1944
and that I last saw her alive on Apr 5 1944.

Immediate cause of death — Duration
Cerebral Hemorrhage — 5 days
Due to
Arterio-sclerosis — 8 yrs.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer U. Todd M. D.
Address 735 N. Fulton Ave. Date signed 4/6/44

VS 180

Correct age is especially important. Physicians: please write the cause or death clearly and legibly.

G 15931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G 15931 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Shalbrook Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Shalbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Snyder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21-1875

8. AGE: Years	Months	Days	If less than one day
69	2	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Appraiser
11. Industry or business Custom House

FATHER
12. Name John Snyder
13. Birthplace Md.

MOTHER
14. Maiden Name Anna M. Lesle
15. Birthplace Md.

16 (a) Informant Mrs. Maria G Langmaid
(b) Address 3301 Shalbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (b)
Date rec'd by registrar APR 6 - 1944 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1944 at 4.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1944 to Apr. 3-1944 and that I last saw h alive on Apr. 3 — 1944.

Immediate cause of death	Duration
Aortic Insufficiency.	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac C. Dickson, M. D.
Address 3055 W. North ave Date signed Apr. 5: 44

G 15932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15932 Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3500 Keene Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3500 Keene Ave (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Anne C. Froehlich

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Philip Froehlich — 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 29, 1880

8. AGE: Years	Months	Days	If less than one day
63	9	7	hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Nurse-wife

11. Industry or business

FATHER 12. Name Francis A. Freie

13. Birthplace ?

MOTHER 14. Maiden Name Mary Anna Rolfes.

15. Birthplace Germany.

16 (a) Informant Joseph F. Freie

(b) Address 303 Wengate Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-44 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore

18 (a) Funeral director Leonard J. Buck.

(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

APR 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1944, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Apr 5 1944, and that I last saw h alive on April 1 1944.

Immediate cause of death	Duration, 1 minute
Coronary Occlusion	4 months
Due to Hypertension - Arterio-sclerosis	
Due to	
Other Conditions Cholelithiasis	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas F. Gelsinn M. D.

Address 113 W Mount St. Date signed 4/5/44

5933

JO #78908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G 15933
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 3 mos. 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Newkirk St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Korzep

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Juedlla Korzep (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1890?

8. AGE: Years	Months	Days	If less than one day
53	9	27	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name Konstanti Korzep
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Jablonska
15. Birthplace Poland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Removed (Burial, cremation, or removal) (b) Date thereof 4/7/44 (month) (day) (year)
(c) Cemetery or crematory Martinsburg W. Va.
Location Martinsburg W. Va.

18 (a) Funeral director Allegh Funeral Home
(b) Address Post Office Lonaconing Md.

APR 6 - 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1944, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1944, to 4-5 1944, and that I last saw h[illegible] alive on 4-5 1944.

Immediate cause of death: Exhibitic heart disease with acute insufficiency — Duration: 3 years
Due to
Due to
Other Conditions Nephrosclerosis — Duration: ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Mathna
Address B C H Date signed 3/5/44 (M/D)

G 15934

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 15934 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3424 St. Ambrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3424 St. Ambrose Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary F. Yates

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Richard H. Yates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1862

8. AGE: Years	Months	Days	If less than one day
81	4	11	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name Charles F. Harper
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. O'Donohue
15. Birthplace Washington, D. C.

16 (a) Informant William F. Yates
(b) Address 3424 St. Ambrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Washington, D. C.

18 (a) Funeral director C. Kenna Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

APR 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th, 1944 at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1944 to April 5 1944 and that I last saw her alive on Apr. 5 1944

Immediate cause of death

	Duration
Arteriosclerotic C V Disease	Few Years
Due to Coronary Thrombosis	10 days.
Due to	

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex A Weinstock M. D.
Address 4603 Park Heights Ave. Date signed

G 15935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 15935 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 636 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 H
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard E. Bolden

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-16-6590

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mathilda A. Bolden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 14, 1867

8. AGE: Years	Months	Days	If less than one day
76	4	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk - Store
11. Industry or business

FATHER
12. Name Mr. Bolden
13. Birthplace United States

MOTHER
14. Maiden Name Unknown
15. Birthplace United States

16 (a) Informant Mrs. Catherine Block
(b) Address 636 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wilkes Lamoreaux
(b) Address 1005 W. Baltimore St.

19 (a) (Date received by registrar) Huntington Williams, Registrar
6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1944, at 11.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942, to April 4 1944, and that I last saw him alive on April 4 1944.

Immediate cause of death: Coronary occlusion sudden death — Duration: ?
Due to Paralyzed arteriosclerosis
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris Bokweiler M. D.
Address 54 S. Fulton Ave. Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G 15936 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Golden Ring~~ Lombard & Greene 24
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural — Race
(If outside city or town limits, write RURAL and give town)
(d) Street No. Golden Ring & Race Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs Mary J. Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband ~~or wife~~ Mr Frank Miller
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) ? 1896

8. AGE: Years	Months	Days	If less than one day
48 47	?	?	hr. min.

9. Birthplace Virginia ? (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name ? Henry Kistler
13. Birthplace Baltimore

MOTHER
14. Maiden Name ? Annie Etelison
15. Birthplace Baltimore

16 (a) Informant Frank Miller
(b) Address Golden Ring & Race Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8-44 (month) (day) (year)
(c) Cemetery or crematory Evans Presbyterian
Location York Road

18 (a) Funeral director Henry Lutz
(b) Address 1203 N. Broadway

19 (a) [illegible] (Huntington Williams M.D.)

APR 7 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1944, at 12 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1944 to 4-5 1944, and that I last saw her alive on 4-5 1944

Immediate cause of death Pulmonary infarction and edema — Duration

Due to Mural thrombi + emboli to pulm. arteries.

Due to Rheumatic Fever Mitral stenosis

Other Conditions Cyanosis + edema

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Mitral stenosis Pulmonary infarct at lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L Roy W Teh M.D.
Address University Hosp. Date signed 4-5-'44

452010 15937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

G 15937
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 PARK ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRENE SPENCER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-19-95

8. AGE: Years	Months	Days	If less than one day
49	2	16	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation HOUSEWORK

11. Industry or business

FATHER
12. Name Clayton -
13. Birthplace

MOTHER
14. Maiden Name NORMA HAWKINS
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 10. 44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md.,

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St
Huntington Williams Md

19 (a) APR 7 - 1944 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APR 5 1944, at 2.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from APR 3 1944, to APR 5 1944, and that I last saw her alive on APR 5 1944.

	Duration
Immediate cause Pulmonary edema	
Due to Meningococcal	5 days
Due to meningitis	
Due to	
Other Conditions Hypertensive cardiovascular dis	
(Include pregnancy within 3 months of death)	
Date of operation Obesity	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R Brinkmann JHH

Address Date 4-5

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 15938

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 15938
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ropin Der (Bow Lui Tse Der)

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Chinese	married

6 (b) Name of husband or wife Could not ascertain
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 3-1893

8. AGE: Years	Months	Days	If less than one day
50	6	1	hr. min.

9. Birthplace Canton - China (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Restaurant

FATHER
12. Name Charlie Der Sing
13. Birthplace Canton China

MOTHER
14. Maiden Name Lee Shee
15. Birthplace Canton - China

16 (a) Informant Mr. James Wu
(b) Address 406 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-7-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Stewart Memorial Co.
(b) Address 1018 W North Ave.

APR 7 1944 (Date rec'd by Local Registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1944, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed April 5, 1944.

VS 151

452026
G 15933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 15939 Registered No.

Please write plainly. Physicians: please write the causes of death clearly and legibly. Give correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Edmondson (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Augusta Breyer
3 (b) If veteran, name war
3 (c) Social Security Account None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife J. George Breyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 4 - 66

8. AGE: Years	Months	Days	If less than one day hr.	min.
77	4	2		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Christopher Kaiser
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Biesman
15. Birthplace Germany

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** April 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 APR 7 - 1944 (Date rec'd by registrar) (b) Lemuel Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944 at 10.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1944 to April 6 1944 and that I last saw h-er alive on April 6 1944

Immediate cause of death Heart failure

Due to Carcinoma of colon.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April - 4, 1944

Major findings of operation: Carcinoma of descending colon

of autopsy: None.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp. Date signed 4-6-44

VS 180

452166 G 15940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 72a

G 15940 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Walcott Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

15A

3 (a) FULL NAME Cynthia Aarons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-25

8. AGE: Years 19 | Months 2 | Days 15 | If less than one day hr min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Aarons
13. Birthplace Russia

MOTHER 14. Maiden Name Jeanne Glass
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Balto. Md

18 (a) Funeral director Jack Lewis Inc
(b) Address 1434 E. Baltimore St

19 (a) APR 7 1944 (Date registrar) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 7 1944, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 5 1944 to Apr 7 1944 and that I last saw her alive on Apr 7 1944.

Immediate cause of death: ventricular fibrillation
Due to Bronchopneumonia
Due to Idiopathic aplastic anemia
Due to Cause

Duration
2 min
36 hrs
? 3 wks

Other Conditions Thrombocytopenic purpura (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laura Disbrow M.D.
Address Johns Hopkins Hosp Date signed 4/7/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15941

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 15941 Registered No. 12 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 534 E. Clement St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 534 E. Clement Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Conroy

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-93

8. AGE: Years	Months	Days	If less than one day
50	6	10	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Mechanist
11. Industry or business Maryland Steel Co.

FATHER
12. Name Thomas J. Conroy
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Ella Gatchsmith
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. William Hauck
(b) Address 534 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 10/44 (month) (day) (year)
(c) Cemetery or crematory Catholic Cem.
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 (a) (Date rec'd by registrar) APR 7 1944 (b) Huntington Williams (Signature of registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6- 1944 at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 4-7-44

G 15942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G 15942 Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 704 S.CONKLING ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 704 S.CONKLING ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MATHIAS L.JOERG

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife MARGARET JOERG

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG.8 1860

8. AGE: Years	Months	Days	If less than one day
83	7	27	hr. min.

9. Birthplace BALTIMORE MD? (Town, county, and state)

10. Usual Occupation RETIRED LABORER

11. Industry or business

FATHER 12. Name MATHIAS JOERG

13. Birthplace GERMANY

MOTHER 14. Maiden Name KATHERINE PFEIFFER

15. Birthplace GERMANY

16 (a) Informant MRS?CHARLES WEINBECK(SISTER)

(b) Address 704 S.CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR.8/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler ORG

(b) Address 403 S.WOLFE ST.

APR 7 - 1944 (Date received by Registrar) (b)

Huntington Whitehurst, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 4 1944 at 10/45 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1943 to 4/4 1944. and that I last saw h alive on 3/31 1944.

Immediate cause of death Chronic Myocarditis Duration

Acute Cardiac Dilatation

Due to Chronic Myocarditis

Due to

Other Conditions Chronic Passive Congestion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature J. H. Snell

Address 1325 S. Conkling Date signed 4/7/44

G 15943 G 15943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 154 Windermere Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Hugh McNeil Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Viola Coutts McNeil
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1874

8. AGE: Years	Months	Days	If less than one day
69	5	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Hugh McNeil Sr.
13. Birthplace Scotland

MOTHER
14. Maiden Name Alice E Rynehart
15. Birthplace Ireland

16 (a) Informant H Ronald McNeil
(b) Address 154 Windermere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 10-1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Bertram Love
(b) Address 2334 E Chase St

19 (a) ..... (b) Huntington Williams, M.D. Registrar
(Signature of local registrar)

APR 7 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944, at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1944, to April 7 1944, and that I last saw h[illegible] alive on April 6 1944.

Immediate cause of death Hypertensive C.V.D.

Duration

Due to .....

Due to .....

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature C. Herman Williams M. D.
Address Md. Gen. Hosp Date signed 4-7-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15944

AB-87221 G 15944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2012 W. Lexington St.

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME George W. Krogman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 27-1882

8. AGE: Years	Months	Days	If less than one day
61	10	8	hr. ..... min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business .....

FATHER

12. Name George W. Krogman (D)

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Gross

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof 4-8-44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore

18 (a) Funeral director Hildebrandt & Cole

(b) Address 1205 N. Lombard St

APR 7 - 1944

(a) ..... (b) .....

(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1944, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31 1944, to 4/4 1944, and that I last saw h[illegible] alive on 4/4 1944.

Immediate cause of death Pulmonary edema; anemia; cardiac failure

Duration

Due to H.C.V.D.

Due to .....

Other Conditions Ventral hernia; old tubal pregnancy

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury .....

23. Signature E. L. Seipman M. D.

Address BCH Date signed 4/4

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

G 15945

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Baltimore Maryland

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Glen Burnie

(If outside city or town limits, write RURAL and give town)

(d) Street No. Lombardy Road

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lizzetta Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: George W. Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1878

8. AGE: Years	Months	Days	If less than one day
65	5	8	hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Piebert

13. Birthplace Germany

MOTHER 14. Maiden Name Hannah Wallace

15. Birthplace Germany

16 (a) Informant Mr. George B. Davis

(b) Address 54 Pontiac Rd Dundalk

17 (a) Burial (b) Date thereof 4-8-64

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Frederick A. Voss

(b) Address 1200 W Lombard St

19 (a) (b)

(Date received by registrar) Hamilton Williams Deputy H.R.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1964, at 12:20 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage of Intracranial

Due to Arteriosclerotic Cardiovascular-renal disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Medical Examiner

Date signed April 5, 1964

15946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 15946 Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5010 Harford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State Md b County
c City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
d Street No. 5010 Harford Rd.
(If rural, give location)
e Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | **5. Color or race** white | **6 (a) Single, married, widowed, or divorced.** married

6 (b) Name of husband or wife Louise Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-1869

8. AGE: Years 75 | Months 2 | Days 22 | If less than one day: hr. min

9. Birthplace Petersburg, Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Louise Miller
(b) Address 5010 Harford Rd.

17 (a) Burial (b) Date thereof 4-10-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 APR 7 - 1944 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1944, at 10 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 1943 to 4/5 1944, and that I last saw h[illegible] alive on 4/5 1944

Immediate cause of death
Chronic Myocardial Insufficiency, Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
a Accident, suicide, or homicide
b Date of occurrence at M
c Where did injury occur?
(City or town) (County) (State)
d Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
e Means of injury

23. Signature [illegible] Fahey M. D.

Address 5703 Harford Rd Date signed 4/6/44

15947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V117a

G 15947
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3035 Westfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. yrs., mos., or days 27-5
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore
(If outside city or town limits write RURAL and give town)
d Street No. 3035 Westfield Ave.
(If rural give location)
e Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Charles J. Sweeddale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mary A. nee Humphrey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-1872

8. AGE: Years	Months	Days	If less than one day
72	3	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Ernest G. Funke
(b) Address 3035 Westfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-44 (month, day, year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Baltimore

18 (a) Funeral director Leonard J. Fuchs
(b) Address 5305 Harford Rd.

19 (a) APR 7 1944 (Date received by registrar) (b) Hunter for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1944, at 11:58 M

21. I certify that death occurred on the date above stated, that I attended deceased from March 1943, to April 5 1944, and that I last saw h in alive on April 5 1944.

Immediate cause of death: Gastric ulcer with Hemorrhage and Obstruction — Duration: 1 year 1 week

Due to: Generalized arteriosclerosis with hypertension — Duration: about year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
(f) Signature E Dalen
Address 6217 Harford Rd Baltimore 14, Md. Date signed 4/9/44

G 15948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

G 15948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 204 W. 27th St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a. State Md. b. County

c. City or town Baltimore (If outside city or town limits, write RURAL and give town)

d. Street No. 204 W. 27th St. (If rural give location)

e. Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MARGARET A. RITTER

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Adam N. Ritter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/1869

8. AGE: Years 75 | Months 0 | Days 1 | If less than one day: hr min

9. Birthplace Clark Co., Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Murray

13. Birthplace England

MOTHER 14. Maiden Name Mary Chapman

15. Birthplace England

16 (a) Informant Mrs. Viola R. Beasman

(b) Address 430 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address 1044 Balto., Md.

19 (a) APR 8 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1944, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1944, to April 7, 1944, and that I last saw h[illegible] alive on Feb 6, 1 P.M. 1944.

Immediate cause of death: Myocarditis

Due to (Long standing heart condition and old age)

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

Duration: Immediate, 2 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Horace D. Liberson M.D.

Address 10 Whitfield Road, Date signed 4/7/44

RECEIVED

G 15949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1278 Registered No. G 15949

The ... should be carefully supplied. ... information ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 641 N. Bentalou St.
(c) Hospital or institution:

16-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore
(If outside city or town limits, write RURAL and give town)
d Street No. 641 N. Bentalou St.
(If rural give location)
e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM A. WEIDNER

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie E,
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 21, 1867

8. AGE: Years: 76 | Months: 6 | Days: 14 | If less than one day: hr min

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual Occupation: Carpenter & Builder
11. Industry or business:

FATHER
12. Name: George F. Weidner
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Mary E. Newton
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Annie E. Weidner
(b) Address: 641 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 4/8/44 (day) (year)
(c) Cemetery or crematory: Parkwood Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

APR 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 5, 1944, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1944 to April 5 1944 and that I last saw him alive on April 4 1944.

Immediate cause of death: Uremic poisoning — Duration: 3 months

Due to Prostatic Stasis

Due to

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence — at M
(c) Where did injury occur? ~
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Chilcoat M. D.
Address 1939 Edmondson Ave Date signed

G 15950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 22a

G 15950 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3432 Childs Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 26 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3432 Childs Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Clarence G. Collier

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1-43

8. AGE: Years | Months 23 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jessie Filbert Collier
13. Birthplace Standardsville Va

MOTHER
14. Maiden Name Eva V. Medaiel
15. Birthplace Standardsville Va

16 (a) Informant Mr Jessie G. Collier
(b) Address 3432 Childs Court

17 (a) (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)
(c) Cemetery or crematory Standardsville Va Cem
Location Standardsville Va.

18 (a) Funeral director Milton Schilling
(b) Address 3414 S. Hanover St

19 (a) Balto 25 Md
(b) Date rec'd by registrar 4/10/44 Huntington Williams M.D

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944 at 3:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 5 1944 to April 7 1944 and that I last saw him alive on April 7 1944.

Immediate cause of death Bronchopneumonia — Duration 5 days
Due to La Grippe — 10 days
Due to
Other Conditions Rickets
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon D. Dorsey M. D.
Address 700 Penn St Balto Md Date signed 4/7/44

VS 8

15951 451762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15951
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry made on information known or obtainable. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 S Binney St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Burns
3 (b) If veteran, name war C
3 (c) Social Security Account No. none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 7-2-29
8. AGE: Years 14 Months 9 Days 3 If less than one day hr min
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
MOTHER / FATHER
12. Name John Burns
13. Birthplace Balto Md
14. Maiden Name Mary Falkenham
15. Birthplace Balto Md
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 1944 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Frappe Road
18 (a) Funeral director Kendel Hooper
(b) Address 312 J. Hg Blvd Ave
19 APR 5 - 1944 (Date to be registered) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 5 1944, at 455 A M
21. I certify that death occurred on the date above stated; that I attended deceased from MAR 29 1944, to Apr 5 1944, and that I last saw her alive on Apr 5 1944.

	Duration
Immediate cause of death: Cardiac failure Pulmonary Edema	7 days
Due to: Rheumatic heart disease	4 wks.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert E Farber
Address Johns Hopkins Hospital Date signed 4/5/44

VS 150

G 15952

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a. ✓ Registered No. G 15952

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St 14
(c) Hospital or institution: South Balto Genera Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christie Jack

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 - 1869

8. AGE: Years	Months	Days	If less than one day hr.	min.
75	6	6		

9. Birthplace Port Deposit Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Jack
13. Birthplace Port Deposit Md.

MOTHER
14. Maiden Name Jane Tipping
15. Birthplace Port Deposit Md.

16 (a) Informant J. E. Tyson
(b) Address Rising Sun Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 1944 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hopewell
Location Port Deposit Md.

18 (a) Funeral director J. E. Tyson
(b) Address Rising Sun Md.

19 (a) APR 8 - 1944 (Date rec'd by Registrar) Thurlow Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 1944, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature [illegible] M.D. Medical Examiner
Date signed 7/7/44

G 15953 | BALTIMORE CITY HEALTH DEPARTMENT ✓ G 15953

CERTIFICATE OF DEATH

Registered No. 1178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 N. Linwood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin A. Ogle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Margaret Kupfer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/4/93

8. AGE: Years	Months	Days	If less than one day hr.	min.
51 yrs.	-	1		

9. Birthplace Baltimore, Maryland. (Town, county, and state)
10. Usual Occupation Asst. Foreman
11. Industry or business B.& O. Railroad

FATHER
12. Name George F. Ogle
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rozeller Houck
15. Birthplace Baltimore

16 (a) Informant Mrs. Margaret Ogle
(b) Address 113 N. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/44 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer.
Location Belair Road.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 APR 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 19 44 at 2.45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/5 19 43 to 4/3 19 44, and that I last saw h[illegible] alive on 4/3 19 44

Immediate cause of death Coronary thrombosis

Duration

Due to ------

Due to

Other Conditions peptic ulcer ? stokes adams disease ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Greenberg M.D.
Address 601 3 Eas[illegible] Date signed 4/6/44

15954

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G 15954
Registered No.

CERTIFICATE OF DEATH 44a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 3/7/44 12
(e) Length of stay in Baltimore (yrs., mos., or days) Since 3/7/44

2. USUAL RESIDENCE OF DECEASED
a State Pa. b County
c City or town Houston
(If outside city or town limits, write RURAL and give town)
d Street No. 220 Grant Street
(If rural give location)
e Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LEONARD RICHARD MIKELONIS

3 (b) If veteran, name war –
3 (c) Social Security Account No. 174-12-0994

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1924

8. AGE: Years 19 | Months 10 | Days 12 | If less than one day hr min

9. Birthplace Castle Shannon, Pa.
(Town, county, and state)
10. Usual Occupation Galleyman-Merchant Marine
11. Industry or business "

FATHER
12. Name William Mikelonis
13. Birthplace Lithuania

MOTHER
14. Maiden Name Josephine Matthews
15. Birthplace Lithuania

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-44 (month) (day) (year)
(c) Cemetery or crematory Houston
Location Houston, Penna.

18 (a) Funeral director G. Lee Oder
(b) Address Houston, Penna.

APR 8 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1944, at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 7, 1944, to Apr. 6, 1944, and that I last saw him alive on Apr. 6, 1944

Immediate cause of death
Meningoencephalomyelitis, acute — several days

Due to

Due to

Other Conditions **Lymphogranuloma, inguinal, venereal** — Unk.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **None done**

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury U S Navy

23. Signature [illegible] M. D.
Address Baltimore, Md. Date signed 4/6/44

VS-51550

15955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

22a

Registered No. 15955

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 828 N. Carey

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town Baltimore (If outside city or town limits, write (C.R.), and give town)

(d) Street No. 828 N. Carey (If rural give location)

(e) Citizen of foreign country? Yes or No ✓

If yes, name country

3 (a) FULL NAME Geneva Brown Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Ralph Turner

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1915

8. AGE: Years 28 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Benjamin Brown

13. Birthplace Baltimore

MOTHER

14. Maiden Name Bertha Wright

15. Birthplace Richmond, Va.

16 (a) Informant Ralph Turner

(b) Address 828 N. Carey

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/44 (month) (day) (year)

(c) Cemetery or crematory Greenlawn

Location Md.

18 (a) Funeral director Leo A. Kelly

(b) Address 1323 Pressman St

19 (a) APR 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1944 at 6:20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 15 1944 to Apr. 5 1944 and that I last saw her alive on Apr 5 1944

Immediate cause of death: Acute Myocarditis — Duration: 2 Days

Due to: Virus Pneumonia — 2 weeks

Due to: Acute Miliary Tuberculosis — 3 mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. L. Loy Lewis M. D.

Address 1402 Ot. Chas Date signed Apr 7 44

15956

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 15956
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 mosher st
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2d years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 mosher st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME mary Blanch Taylor

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	Widowed

6 (b) Name of husband or wife Thomas Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1899

8. AGE: Years	Months	Days	If less than one day
44	9	28	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Hilary Fenwick
13. Birthplace md

MOTHER
14. Maiden Name Josephine matthews
15. Birthplace md

16 (a) Informant mary martin
(b) Address 1407 mosher st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-44 (month) (day) (year)
(c) Cemetery or crematory mt auburn
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Presstman st

19 APR 8 - 1944 (b) H. Livingston Miller, M.D. Registrar
(Date received by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH april 4 1944, at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3 1944 to 4/4 1944 and that I last saw h alive on 4/3 1944.

Immediate cause of death — Duration
Pt Lobar Pneumonia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Bucklesome
Address 1131 Harlem Date signed 4/7/44

15957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G 15957
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 Woodyear Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew D. Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION 8:30

20. DATE OF DEATH April 5, 1944, at A. M

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 12, 1928

8. AGE: Years: 16 S.T. | Months: — | Days: 23 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fred Queen
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Stovall
15. Birthplace Md.

16 (a) Informant Elizabeth Queen
(b) Address 1144 Woodyear Ave

17 (a) Burial (b) Date thereof 5/6/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelso
(b) Address 1303 Pleasant Ave

19 (a) APR 8 - 1944 (b) Christopher Williams, M.D.
(Date rec'd by registrar) Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Rupture of Liver, traumatic

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-4-44 at 8:20 P. M. 11-2
(b) Where did injury occur? Carrollton Ave & Mulberry Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 5, 1944.

VS 151

G 15958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

G 15958
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH SOLLY

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 8-28-1937

8. AGE: Years	Months	Days	If less than one day
6	7	9	hr. min.

9. Birthplace Baltimor Md (Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name William Jolley
13. Birthplace S. C.

MOTHER
14. Maiden Name Helen Roseborough
15. Birthplace S. C.

16 (a) Informant William Jolley
(b) Address 1403 Argyle ave
17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 4-8-44. (month) (day) (year)
(c) Cemetery or crematory Elvira cemetery
Location Chester South Carolina
18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave
19 (a) (b) Huntington Williams

APR 8 1944

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1944, at 4:25 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-26-44 at 1 P. M.
(b) Where did injury occur? Brunt + Lafayette Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by auto.

23. Signature H L Wollenweber M.D. Medical Examiner
Date signed 4-6-44

G 15959 TN. 87182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15959 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 S. Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country Ireland

3 (a) FULL NAME Thomas Lyons

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Sps. American War	None	Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1877

8. AGE: Years	Months	Days	If less than one day hr.	min.
67	?	?		

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

MOTHER / FATHER
12. Name ? Michael Lyons
13. Birthplace Ireland
14. Maiden Name Catherine Jenkins
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (records
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 / 8 / 44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.
18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.
19 (a) APR 9 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1944, at 5:20 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1944 to 4/5 1944, and that I last saw h alive on 4/5 1944.

Immediate cause of death: Lobular pneumonia — Duration: 5 days
Due to
Due to
Other Conditions Bronchoscesis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Dr above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul O'Rourke
Address B.C.H. Date signed 4/6/44 M.D.

G 15960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

G 15960 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette ave 700
(c) Hospital or institution: Hospital for women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Mildred Thompson

3 (b) If veteran, name war W | 3 (c) Social Security Account No. NONE

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Arthur Thompson

6 (c) If alive, ~~give~~ age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1884

8. AGE: Years 59 | Months 5 | Days 6 | If less than one day ~~X~~ hr. ~~X~~ min.

9. Birthplace Annapolis Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name Wm. U. Stinchcomb

13. Birthplace A. A. Co. Md.

MOTHER 14. Maiden Name Jane Stallings

15. Birthplace A. A. Co. Md.

16 (a) Informant Nancy Bearett

(b) Address 420 Poplar Grove St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/8/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 317 N. Paul St

19 (a) APR 8 - 1944 (Date rec'd by registrar) Hunting for Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944, at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/44 19__ to 4/6/44 19__, and that I last saw her alive on 4/5/44 19__.

Immediate cause of death: Heart failure — Duration 24 hrs

Due to Lower diffuse nodular Thyroid — Duration 10 yrs

~~Due to~~ Goitre post-operative — Duration 6 months

Other Conditions: Hypertension (Include pregnancy within 3 months of death)

Date of operation 4/4/44

Major findings of operation: Large diffusely nodular and hyperplastic

If autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Felix Rutledge M. D.

Address Womens Hospital Date signed 4/6/44

G 15961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 15961 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4512 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4512 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA CARRICK

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Lackey M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1859

8. AGE: Years	Months	Days	If less than one day
84	9	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Henry Carter
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Lemmon
15. Birthplace Maryland

16 (a) Informant Mr. Arthur B. Carrick
(b) Address Timber Grove Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) APR 8 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1944 at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1944 to April 19
and that I last saw h[illegible] alive on April 6 1944.

Immediate cause of death
(a) Metastatic Heart Disease (Regurgitation)
Due to
(b) Del Confinement (cancer) Duration unknown
Due to Fracture of Rt Femur at hip joint 30 dr.
Other Conditions
Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide or homicide~~ March 8 - 1944
(b) Date of occurrence 3-8-44 at A M
(c) Where did injury occur? Her home (City or town) (County) (State)
(d) Did injury occur about home, ~~on farm, industrial place, in public~~ place? Yes (Specify type of place) While at work? No
(e) Means of injury Fell and fractured hip

23. Signature C. D. Eyrich M. D.
Address 7201 4th Rd Date signed 4-7-44

Huntington Hillcrest M.E. Registrar
Approved by Howard J. Madden, M.D.

G 15962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G 15962

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 700 E. 26th St. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Mr. Joseph Kurtz

3 (b) If veteran, name war: W

3 (c) Social Security Account No. NONE

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Edna Emelie Kurtz

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 24th 1893

8. AGE: Years: 51 | Months: 1 | Days: 12 | If less than one day: hr ..... min.

9. Birthplace: Austria-Hungary (Town, county, and state)

10. Usual Occupation: Baker

11. Industry or business: Own Business

FATHER

12. Name: John Kurtz

13. Birthplace: Austria-Hungary

MOTHER

14. Maiden Name: Unknown

15. Birthplace: Austria-Hungary

16 (a) Informant: Edna E. Kurtz

(b) Address: 700 E. 26th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~: Parkwood

Location: Parkville Md.

18 (a) Funeral director: Wm Zorn Inc

(b) Address: 1 Huntington Ave Pennsylvania, Md.

APR 8 1944 (b) .....

(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944, at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 1944 to 4/6 1944, and that I last saw h[illegible] alive on 4/6 1944.

Immediate cause of death: Cause of Coma

1 year: Failure

Due to: Renal Insufficiency

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

If autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Dr. H. E. Wallace M. D.

Address 1400 N. Caroline Date signed 4/6/44

G 15963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 R

G 15963 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Howard & Madison

(c) Hospital or institution: Maryland General

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4805 Cordelia Av. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. Preston H. Wantz

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 214-01-9951

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Effie A. Wantz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
48	10	15		

9. Birthplace Bells Mill, Md. (Town, county, and state)

10. Usual Occupation Construction Man

11. Industry or business McCormick Asbestos Co

FATHER — 12. Name Stuart S. Wantz

13. Birthplace Pond Mill, Md.

MOTHER — 14. Maiden Name Ida Phillips

15. Birthplace Hamden Md.

16 (a) Informant John F. Slack

(b) Address 4831 Cordelia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 44 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Baltz. Co. Md.

18 (a) Funeral director Wm Cook Sec

(b) Address 1217 E. Paul St

19 APR 8 - 1944 (Date rec'd by registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1944, to April 7 1944, and that I last saw him alive on April 7 1944.

Immediate cause of death	Duration
Peritonitis	
Due to Intestinal Obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. Herman Williams M. D.

Address Md. Gen. Hosp. Date signed 4-7-44

G 15964

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 44a

G 15964
Registered No.

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Joh. Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martin T. Collins

3 (b) If veteran, name war: W.
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of ~~husband or~~ wife: Virginia V. Collins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 71

8. **AGE:** Years 66 | Months 10 | Days 18 | If less than one day: 19 hr. min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual Occupation: Retired Clerk
11. Industry or business: Pa. R.R.

FATHER
12. Name: (Unknown) Collins
13. Birthplace: Ireland

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Virginia T. Collins
(b) Address: 719 E. Biddle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 10 44 (month) (day) (year)
(c) Cemetery ~~or crematory~~: New Cathedral
Location: Balto. Md.

18 (a) Funeral director: Wm. Cook Inc
(b) Address: 219 E. Saratoga St

19 (a) [illegible] (b) [illegible] P.
(Date rec'd by registrar) Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 19 44 at 2.05 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. McNally M.D. Medical Examiner
Date signed 4/7/44

15965 G 15965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1031 Ashburton St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Lola V. Hefner

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife: Elmer A. Hefner
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, year): Feb 20th 1909

8. AGE: Years	Months	Days	If less than one day
34	36 + 6	17	..... hr. ..... min.

9. Birthplace: Baltimore (Town, county and state)
10. Usual Occupation: housewife
11. Industry or business: At Home

FATHER
12. Name: Oliver Interriden
13. Birthplace: Delta, Md.

MOTHER
14. Maiden Name: Mary Tomlinson
15. Birthplace: Urbanna Va.

16 (a) Informant: Elmer Hefner
(b) Address: 1031 Ashburton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Balto Md.

18 (a) Funeral director: William Cox
(b) Address: 1517 W. Pratt St

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1944, at 2:07 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1944 to 4/7 1944
and that I last saw her alive on 4/7 1944.

Immediate cause of death: Uremia — Duration: Several days

Due to: 4th degree extension of Carcinoma of cervix — Duration: about 1 yr.

Due to: .....

Other Conditions: Post radiation therapy (Include pregnancy within 3 months of death)

Date of operation: .....

Major findings of operation: .....

of autopsy: Extension of Ca of cervix & blockage of ureters

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature: Irving J. Taylor
Address: West Balto Gen'l Hosp. Date signed: 4/7/44

15966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. C 15966

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3126 Odonnell Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
a. State Md. b. County
c. City or town Baltimore 24, (If outside city or town limits, write RURAL and give town)
d. Street No. 3126 Odonnell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Lewatowski

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~XXXXX~~ Anthony Lewatowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 26-1876

8. AGE: Years	Months	Days	If less than one day
67 68	5	10	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Augustyniak

13. Birthplace Poland

MOTHER 14. Maiden Name Veronica Dluniak

15. Birthplace Poland

16 (a) Informant Lillian Schubert (Daughter)

(b) Address 3126 Odonnell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-44 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Baltimore, Md.

18 (a) Funeral director George A. Weber

(b) Address 705 South Ann Street

19 (a) (Date received by registrar) 4-8-1944 (b) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944, at 7.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1943 to April 6 1944 and that I last saw her alive on April 6 1944.

Immediate cause of death	Duration
ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	1 YEAR
Due to	
Due to	
Other Conditions 1- BRONCHO-PNEUMONIA	4/4/44
2-UMBILICAL HERNIA	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: NONE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Drenga, M.D.

Address 207 S. Chester St Date signed 4/6/44

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

15967

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 15967

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2736 Odonnell Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City, (If outside city or town limits, write RURAL and give town)
(d) Street No. Folly Quarter (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ven, Brother Anthony Magalenga O.M.C.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan, 7-1878

8. AGE: Years	Months	Days	If less than one day
66	2	29	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Religious Brother
11. Industry or business Franciscan Order

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Rev. James Cholewka O.M.C.
(b) Address 2736 Odonnell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-1944 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (Date received by registrar) Apr 8 1944 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1944, at 8:25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 19 44, to April 5, 19 44, and that I last saw him alive on April 5 1944.

	Duration
Immediate cause of death Chronic valvular heart disease	years
Due to Chronic asthmatic bronchitis	years
Due to Arterio-sclerosis	years
Other Conditions Myocardial insufficiency 12 hr	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury I. B. Bronshas, M.D.

23. Signature I. B. Bronshas,
Address 3037 O'Donnell St Date signed 4-7-44

correct age is especially important. physicians please write the words of death clearly and legibly.

G 15968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 15968 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Marluth Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County - - -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Fleet St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET (MAGGIE) HERMAN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: John R. Herman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 25.1880
8. AGE: Years 63 | Months 9 | Days 10 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Adam Glock
13. Birthplace Germany

MOTHER
14. Maiden Name Anna C.M. Vogeding
15. Birthplace Germany

16 (a) Informant Miss Alice M. Herman
(b) Address 1809 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 8. 1944 (month) (day) (year)
(c) Cemetery or crematory St. Paul's 5th Ref.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway.

19 APR 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 5. 1944 at 4.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 44 to Apr 5 44, and that I last saw h alive on Apr 5 44

Immediate cause of death: Cerebral Hemorrhage
Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Insley M. D.
Address 2956 E Balt Date signed 4-7-44

correct age is especially important. registrar: please write this entry carefully and legibly.

VS 250

G 15969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15969

Registered No. 120

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1821 N. Castle St.

(c) Hospital or institution:

8-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County - -

(c) City or town Baltimore -13 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1821 N. Castle St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME JOHN OSBORNE SHECKELLS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	213-01-4466

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife - - -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14. 1897

8. AGE: Years	Months	Days	If less than one day
47	2	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Bottler

11. Industry or business American Brewery

FATHER

12. Name John O. Sheckells

13. Birthplace Baltimore

MOTHER

14. Maiden Name Elizabeth Hagerty

15. Birthplace Baltimore

16 (a) Informant Mrs. Frances E. Sheckells

(b) Address 1821 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 10. 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.

Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address North Ave. & Broadway.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

APR 8 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8. 1944 at 3.13 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1941, to 4/6 1944.

and that I last saw h[illegible] alive on 4/5 1944.

Immediate cause of death	Duration
Pulmonary tuberculosis.	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Max Baum M.D.

Address 1501 N. Milton Ave Date signed 4/7/44

15970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15970 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 Mt. Clare St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth O'Neill

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Thomas H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3. 1869

8. AGE: Years	Months	Days	If less than one day
74	10	4	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name	Wm D. —
FATHER — 13. Birthplace	Ireland
MOTHER — 14. Maiden Name	Margaret Gray
MOTHER — 15. Birthplace	Ireland

16 (a) Informant Wm H. O'Neill
(b) Address 109 Mt Clare St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Doll & B. M. Walters
(b) Address Pratt & Stockton St

19 (a) 4-8-1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1944 at 3:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions Generalized Atrophic Arthritis (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Williams M.D. Medical Examiner
Date signed 4/7/44

VS 151

15971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 15971
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Comet Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Potter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name McKinley Gay
13. Birthplace Virginia

MOTHER
14. Maiden Name Margaret Potter
15. Birthplace Maryland

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL APR 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

APR 8 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1944, at 11.55P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1944, to March 28 1944, and that I last saw h im alive on March 28 1944.

Immediate cause of death Pneumonia — Duration

Due to Prematurity
Maternal Intrapartum Infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip O. Stephens
Address Johns Hopkins Hospital Date signed 4 M 1944

correct age is especially important. If uncertain, please write the causes of death clearly and legibly.

VS 180

0853

15972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 15972

159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 Riggs Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby "B" Sims Twin # 2

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1944

8. AGE: Years	Months	Days	If less than one day
			14 hr. 33 min

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ira A. Sims
13. Birthplace Arkansas

MOTHER
14. Maiden Name Jonoliver Handley
15. Birthplace Arkansas

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL APR 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) APR 8 1944 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944, at 9.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1944, to March 27 1944, and that I last saw h im alive on March 27 1944.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stephoe, Jr. M. D.
Address Johns Hopkins Hospital Date signed 4/3/44

0852

correct age if especially important. If unknown, please write the causes of death clearly and legibly.

15973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G 15973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

16-5

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 Riggs Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "A" Sims

Twin # 1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1944

8. AGE: Years	Months	Days	If less than one day
			14 hr. 50 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ira A. Sims
13. Birthplace Arkansas

MOTHER
14. Maiden Name Jonoliver Handley
15. Birthplace Arkansas

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL APR 5 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 8 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

0851

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1944, at 9.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1944, to March 27 1944, and that I last saw him alive on March 27 1944.

Immediate cause of death Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stapleton, Jr.
Address Johns Hopkins Hospital Date signed 4/3/44

15974257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √159

G 15974
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 256
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1447 Binder Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 - 11 - 44

8. AGE: Years | Months | Days 24 | If less than one day hr. 23 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

MOTHER / FATHER

12. Name Henry White

13. Birthplace S.C.

14. Maiden Name Irene Lesbit

15. Birthplace Ga.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location JOHN HOPKINS MEDICAL SCHOOL APR 5 1944

Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) APR 8 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1944 at 3 29 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 19 1944 to April 4 1944 and that I last saw her alive on April 4 1944

Immediate cause of death: respiratory failure — Duration: Immed.

Due to: prematurity — Duration: 24 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M. D.
Address John Hopkins Hosp. Date signed 4-5-44

0850

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 15975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 15975 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 Light St. 2851
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Hillsdale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Councill (CARRIE M.F. COUNCILL)

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1864

8. AGE: Years 79 | Months 7 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Easton, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Frazier

13. Birthplace Md.

MOTHER 14. Maiden Name Matilda Haddaway

15. Birthplace Md.

16 (a) Informant Mrs. Clarence C. Utley

(b) Address 3708 Hillsdale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) APR 8 - 1944 (Date Rec'd by Registrar) by Hillsdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944, at 6 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26 1944, to Apr. 6 1944, and that I last saw her alive on Apr. 6 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to Fractured hip

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence March 26, 1944 at 7:45 A M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury Fell down at home

23. Signature Paul A. G. Zaleski M. D.

Address 213 Light St. Date signed Apr. 6, 1944

VS 180

For S. C. J. Zubrinski, by Howard L. Wallace, M.D.

G 15976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 15976 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Walbrook Ave.
(c) Hospital or institution: Edgewood Apts. 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME H. DOUGLAS SCHMENNER

3 (b) If veteran, name war: World
3 (c) Social Security Account No. 216-03-6131

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Helena Schmenner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1894

8. AGE: Years	Months	Days	If less than one day
49	4	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk - Manager
11. Industry or business Leather Business

FATHER
12. Name Stonewall J. Schmenner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Ella E. Baltz
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Helena Schmenner
(b) Address 3409 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by local registrar APR 8 1944 (b) Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1944, to 4/6 1944, and that I last saw him alive on 4/6 1944.

Immediate cause of death: Coronary occlusion — Duration: ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emmett Kahn
Address 1734 Pop Gr Dr Date signed 4/8/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15977 — 1944 — Registered No. 16047

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1948 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1948 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred Wesley Hughes

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian O.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 9, 1875

8. AGE: Years: 68 | Months: 5 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Retired Insurance Collector

11. Industry or business:

FATHER
12. Name: Alfred W. Hughes
13. Birthplace: -- Maryland

MOTHER
14. Maiden Name: Martha V. Miller
15. Birthplace: Maryland

16 (a) Informant: Mrs. Gwendolyn McGinn
(b) Address: 1948 W. Mulberry St. 23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)
(c) Cemetery or crematory: Western Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1944 at 11:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1944 to 4/7 1944 and that I last saw him alive on 4/7 1944.

Immediate cause of death: Primary Thrombosis
Terminal Pneumonia — Duration: 2 days

Due to

Due to

Other Conditions: Hypertension C.V. Arteriosclerotic Cardiosclerosis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature: Walter J. Zubrowski M. D.
Address: 517 Cathedral St. Date signed: 4/9/44

Correct age in especially important. Physicians: please write the causes of death clearly and legibly.

VS 8 APR 8 - 1944 8

G 15978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No. G 15978

Every item of information should be carefully supplied. Where exact information is not known, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 19 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 Bancroftwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Elizabeth Streb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-7-44.

8. AGE: Years	Months	Days	If less than one day
			17 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Edwin Henry Streb
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marie Elizabeth Widmar
15. Birthplace Baltimore, Md.

16 (a) Informant Edwin Henry Streb
(b) Address 2902 Bancroftwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Beech Ave. & Cordelia Lane

18 (a) Funeral director Ehrer & Cordelia Low
(b) Address 2246 Eager St.

19 (a) APR 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8 1944 at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 19 44 to 4-8 19 44 and that I last saw h e alive on 4-8 19 44.

Immediate cause of death	Duration
(Fetal)	
Due to Toxemia Nephritis	
Renal disease (Maternal)	
Due to Toxemia.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Vogel Jr. M. D.
Address Bon Secours Hosp. Date signed 4-8-44.

G 15979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 15979 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 69 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 W. Strathmore Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Katharine Roney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------- 1875

8. AGE: Years	Months	Days	If less than one day
69	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name John Roney
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary --------
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret C. Petting
(b) Address 3400 W. Strathmore Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares & Son
(b) Address 805 N. Calvert Street

19 (a) APR 8 1944 (Date received by local registrar) (b) Huntington Williams

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1944 at 3:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944 to 4/5 1944 and that I last saw her alive on 4/5 1944.

Immediate cause of death Congestive Heart Failure

Due to Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy —

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Lynwood Rogers, M. D.
Address Bon Secours Hospital Date signed 4/5/44

Correct age in carefully important. If unknown, please write the causes of death clearly and legibly.

G 15980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G 15980
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N. Mount Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID J. BUCKNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 26, 1926

8. AGE: Years	Months	Days	If less than one day
17	8	9	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Buckner
13. Birthplace Maryland

MOTHER
14. Maiden Name Florinda Thomas
15. Birthplace Maryland

16 (a) Informant Florinda Buckner
(b) Address 535 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1944 (month) (day) (year)

(c) Cemetery or crematory Western Star Cemetery
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) 4-8-1944 (Date rec'd by registrar) Huntington Williams Registrar

V8 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1944 at 9:15 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Burns 2nd & 3rd degrees entire body.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 16/6

(a) Date of injury Apr. 4, 1944 9 P. M.
(b) Where did injury occur? 621 N. Franklintown Road. Factory cleaning Company.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Gasoline on clothes caught fire.

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner
Date signed April 6, 1944.

G 15981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

G 15981 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 Vine Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sampson Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Olivia Thompson
(b) Address 109 Pine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) APR 8 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1944 at 11A, M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronis valvular Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grattan M.D. Medical Examiner.
Date signed April 5, 1944.

G 15982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G 15982 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 537 W. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 537 W. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1880

8. AGE: Years	Months	Days	If less than one day
64	3	-	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Belle Floyd
(b) Address 537 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

DR 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1944, at 11 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/24 1944 to April 6 1944, and that I last saw h[illegible] alive on April 1944

Immediate cause of death: Uremia - Renal — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. N. Halstead M. D.
Address [illegible] Date signed 4/7/44

Huntington Williams, M.D.

G 15983

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 22a

G 15983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md Gen Hosp 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 658 Bradley St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
? 55			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Hospital Porter
11. Industry or business Md Gen Hosp

FATHER
12. Name Horace Millan Lee
13. Birthplace Md

MOTHER
14. Maiden Name Susie Blackaden
15. Birthplace Md

16 (a) Informant James Lee
(b) Address Madison & Linden, Balto Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave. (Interring or Williams, Md)

19 (a) (Date rec'd by registrar) (b) Registrar

APR 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6 1944 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1944 to 4-6 1944. and that I last saw him alive on 4-6 1944

Immediate cause of death: Miliary T.B. toxemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: Miliary T.B.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Md Gen Hosp Date signed 4/6/44 (M.D.)

G 15984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G 15984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 N. 37th Street
(c) Hospital or institution:

13-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N. 37th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Amy C. Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles E. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1879

8. AGE: Years 64 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Frederick Town, Missouri (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Thomas Richard Littleton
13. Birthplace Missouri

MOTHER
14. Maiden Name Anna —
15. Birthplace Missouri

16 (a) Informant Edward F. Bartell
(b) Address 3902 Elgin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-1944 (Month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 2431 Fallsway

19 (b) APR 8 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7- 1944 at 1.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1944, to April 6 1944, and that I last saw h- alive on April 6 1944.

Immediate cause of death
Cancer of Uterus a Metastasis | Duration 1 year

Due to

Due to

Other Conditions Recto-Vaginal Fistula
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Simon V. F. Mackie M. D.
Address 824 N. 37th St Date signed 4-7-44

15985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1218

Registered No. C 15985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, if necessary supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Howard & Madison

(c) Hospital or institution: Maryland General

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7

(e) Length of stay in Baltimore ~~(yrs., mos.,~~ or days) 24

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2600 Maryland Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. Arthur D. Hagy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (Married), widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1889

8. AGE: Years	Months	Days	If less than one day
54	3	27	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER — 12. Name J. C. Hagy

13. Birthplace Va.

MOTHER — 14. Maiden Name Alice Davis

15. Birthplace Va.

16 (a) Informant Edward Hagy

(b) Address 2600 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-44 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem. Pk.

Location Baltimore, Md.

18 (a) Funeral director Durward D. Covington

(b) Address 21 W. 25th St.

APR 8 - 1944 (Date rec'd by registrar) (b) Huntingtn Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944 at 12:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1944 to April 7 1944 and that I last saw h/m alive on April 6 1944.

Immediate cause of death: Pulmonary infarction — Duration

Due to

Due to

Other Conditions Chronic glomerulo nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Herman Williams M. D.

Address Md. Gen. Hosp Date signed April 7, 1944

VS 180

451672 Sackett ✓ G 15986

G 15986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G 15986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as far as possible. Physicians: please write the cause of death clearly and legibly, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 S. Highland (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Augustus J. Sackett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife Mary McAlister

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-61

8. AGE: Years	Months	Days	If less than one day hr.	min.
82	3	28		

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Cyrus Sackett
13. Birthplace N.Y.

MOTHER
14. Maiden Name Mary Schamp
15. Birthplace Ohio

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Annapolis
Location Annapolis

18 (a) Funeral director Frank V. Papaitone
(b) Address 248 E. Baltimore St

APR 8 - 1944 (a) Huntington Williams, M.D. (b) 0 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 27 1944 to April 6 1944 and that I last saw h[illegible] alive on April 6 1944

Immediate cause of death Pyelitis & Staphylococcus septic

Due to Coma.

Due to Benign Prostatic hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: in a Terminal Diag. 4/6/44

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell B Potts

Address Johns Hopkins Hosp Date signed 4/6/44

15987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G 15987
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2428 Eutaw Place.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Eutaw Place.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ? years

3 (a) FULL NAME ABRAHAM BAUMBLATT.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Lina Baumblatt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1862.

8. AGE: Years	Months	Days	If less than one day
81	10	22 21	hr. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation Retired ?
11. Industry or business

FATHER
12. Name Isaac Baumblatt,
13. Birthplace Germany

MOTHER
14. Maiden Name Marianne Fleischer,
15. Birthplace Germany.

16 (a) Informant Mrs. S. B. Hirschman,
(b) Address Larchmont, N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/ 10 /44.
(month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Pl. Balto. Md.

19 APR 8 — 1944 [illegible] Registrar
Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th. 1944 at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 10 1944 to Apl 2 1944 and that I last saw h[illegible] alive on April 2 1944.

Immediate cause of death — Duration

[illegible] Uraemia - Sclerosis — Unknown

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 1720 Eutaw Place Date signed 4/9/44

VS 3

G 15983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15988 Registered No. 81a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Since 3/25/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 George Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CALVIN CARROLL THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1923

8. AGE: Years	Months	Days	If less than one day
20	3	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk-American Store
11. Industry or business -

FATHER
12. Name Joseph Thomas
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Nellie Young
15. Birthplace Baltimore, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem. Balto. Md.
Location

18 (a) Funeral director Mrs Geo. W. Hollan & Son
(b) Address 1631 Druid Hill Ave.

APR 9 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH April 5, 1944, at 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25, 1944, to Apr. 5, 1944, and that I last saw him alive on Apr. 5, 1944.

Immediate cause of death 1. Purulent basillar meningitis, type undetermined; 2. Edema & congestion of lungs & kidneys (due to 1)

Duration: Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/29/44-Spinal puncture
Major findings of operation: See above

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Carlin M. D.
Address Baltimore, Md. Date signed 4/5/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

Va-14389

G 15989 G 15989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1338

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N Caroline St

(c) Hospital or institution: St. Joseph's Hospital 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 12 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State ... County Baltimore

(c) City or town ... (If outside city or town limits, write RURAL and give town)

(d) Street No. unknown (If rural give location)

(e) Citizen of foreign country? ... (Yes or No)

If yes, name country

3 (a) FULL NAME Roy Thomas (Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	~~Married~~

6 (b) Name of husband or wife Corrie Thompson

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Berry Thompson

13. Birthplace S. C.

MOTHER 14. Maiden Name Nora Brown

15. Birthplace S. C.

16 (a) Informant Nora Thompson

(b) Address 225 Amelia St., Spartenburg, S. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-44 (month) (day) (year)

(c) Cemetery or crematory ...

Location Spartanburg, S.C.

18 (a) Funeral director Mrs. Lee M. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) ... (b) ... Registrar

(Date filed by registrar) APR 9 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-1944, at 2:58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1-1944 to 4-6-1944 and that I last saw him alive on 4-6-1944

Immediate cause of death Uremia

Due to Pyonephritis (Bilateral)

Due to ...

Other Conditions ...

(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy: Infected Cystic Kidneys

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ...

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury ...

23. Signature Frank L. Vanni, M. D.

Address St. Joseph's Hosp Date signed 4-6-44

G 15990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15990 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 N. Bethel Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 N. Bethel St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie V. Aro

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Albert L. Aro
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) June 7, 1866

8. AGE: Years	Months	Days	If less than one day
77	10	0	hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Levi Arnett
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary J. Leightzer
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John Howard Aro (Son)
(b) Address 515 Patapsco Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave. Balto. Md

18 (a) Funeral director George J. Ruth Inc.
(b) Address 1235 Harford Ave.

19 (a) 4-9-1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1944 at 11 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 8 1944

G 15991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 15991

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 152 N. Kenwood avenue

(c) Hospital or institution: ----

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 --

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County --

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 152 N. Kenwood ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME ISAAC H. LUDWIG

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widower

6 (b) Name of husband or wife Margaret Rohrer Ludwig

6 (c) If alive, give age-- years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1868

8. AGE: Years	Months	Days	If less than one day
75	6	19	hr min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John G. Ludwig

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Miss Carrie Ludwig

(b) Address 152 N. Kenwood avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Aphasia Road

18 (a) Funeral director Chas. J. Evans Son

(b) Address 118 W. Mt Royal Ave

19 (a) Huntington Williams M.D. (Registrar)

(b) Date received APR 9 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 6 1942 to Apr. 6 1944, and that I last saw h alive on Apr. 1, 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 2 yrs

Due to Arteriosclerosis ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Eugene L. Cessna M. D.

Address 516 Dorsey Lane Date signed 4/7/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 15992

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3714 Manchester Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-15
(e) Length of stay in Baltimore (yrs., mos., or days) 52 YRS. 7 mos 27 dys

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RFD, Rural, and name town)
(d) Street No. 3714 Manchester Ave (If rural give location)
Was deceased a resident of the United States? (Yes or No)
If yes, name country

3 (a) FULL NAME ALMA M. FEAR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F M. | 5. Color or race WHT | 6 (a) Single, married, widowed, or divorced MARRIED.

6 (b) Name of husband HERBERT FEAR.

6 (c) If alive, give age years

7. Birth date of deceased (month, day, year) AUG 10 - 1891

8. AGE: Years 52 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace BALTO (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name ALBERT L. MILLER
13. Birthplace DETROIT MICH.

MOTHER
14. Maiden Name ELIZABETH KELLY
15. Birthplace BALTO MD.

16 (a) Informant H. FEAR.
(b) Address 3714 MANCHESTER AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location FREND. AVE

18 (a) Funeral director GEO. LEIMBACH
(b) Address 25 N LYNDHURST ST

19 (a) APR 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1944, at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1944, to April 6 1944, and that I last saw h alive on 19

Immediate cause of death: Pulmonary Embolism — Duration a few hrs.

Due to Cardiac Decompensation 4 mos.

Due to Chronic Valvular Heart Disease 10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H. Zeller M. D.
Address 2308 Eutaw Place Date signed 4/9/44

G 15993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 15993 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Hoffman
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. William T. Quill

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Amanda A.

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec 1-1870

8. AGE: Years 73 Months 3 Days 7 If less than one day hr min

9. Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Real Estate

11. Industry or business Retired

FATHER
12. Name Morris Quill
13. Birthplace Ireland.

MOTHER
14. Maiden Name Cath. Quill
15. Birthplace Ireland.

16 (a) Informant Amanda A. Quill
(b) Address 511 N. Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/44 (day) (year)
(c) Cemetery or crematory Holy Cr.
Location Belgid Rd

18 (a) Funeral director John G. McJan
(b) Address 5100 E. Balto St.

19 (a) 1944 (b) Huntington Williams M.D. (Date filed by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944 at 6 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from April 7 1944 to April 7 1944 and that I last saw him alive on April 3 1944

Immediate cause of death: Congestive heart failure — Duration

Due to Hypertension

Due to

Other Conditions Upper respiratory infection

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas O Brennan M.D.
Address St Joseph Hospital Date signed 4-7-44

Street age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15994 — BALTIMORE CITY HEALTH DEPARTMENT — G 15994 Registered No.

CERTIFICATE OF DEATH 93 D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 N Monroe
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 N Monroe (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Jane E McFaw

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John W. — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1858

8. AGE: Years 86 | Months 2 | Days 10 | If less than one day hr. min

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Willow
FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Amy Delaney
MOTHER 15. Birthplace Virginia

16 (a) Informant Mrs Mary M Robinson
(b) Address 2 N Monroe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-44 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location Harpers Ferry W Va

18 (a) Funeral director George E Farley
(b) Address Sudlon & Fayette

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, MD

APR 9 VS 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to April 7 1944, and that I last saw h[illegible] alive on April 6 1944.

Immediate cause of death Arteriosclerotic Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M Collins MD M. D.
Address 3321 Fred Ave Date signed 4-8-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 15995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 15995 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Glendale (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Dunbarton Road (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mrs. Virginia Morris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife George Morris
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1879

8. AGE: Years	Months	Days	If less than one day
64 65	5	29	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Levi Calhoun
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Susan Smith
15. Birthplace Texas

16 (a) Informant Hazel Reuss
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, 19 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Lazarus Brecker
(b) Address 5705 Park Heights Ave.

19 (a) APR 10 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 44, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 19 44, to April 6 19 44, and that I last saw her alive on April 6 1944.

Immediate cause of death Pulmonary Edema — Duration 3 Min.
Due to Arteriosclerotic H.D. — ?
Sclerosis of Aortic Valve — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lazarus Brecker M. D.
Address Church Home & Hospital Date signed 4/6/44

15996

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G 15996
Registered No.

CERTIFICATE OF DEATH 46D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens and Caton Aves
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County Hanover
(c) City or town Box 103 (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Cifoni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1889

8. AGE: Years 54 | Months 11 | Days 23 | If less than one day hr. min

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank DENTE (dec'd)
13. Birthplace Italy

MOTHER
14. Maiden Name Catherine BACICALUPO (dec'd)
15. Birthplace Italy

16 (a) Informant FRANK CIFONI (HUSBAND)
(b) Address BOX 103-ANOVER MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/10/1944 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD. BAL. MD.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Monroe St.

APR 10 1944

(a) Registrar (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/1944 at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 .
and that I last saw her alive on 4/6/1944.

Immediate cause of death Spinal Anesthesia — Duration

Due to

Due to

Other Conditions Carcinoma Recto-Sigmoid
C. metastasis
(Include pregnancy within 3 months of death)

Date of operation 4/6/44

Major findings of operation: Carcinoma Recto Sigmoid C metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Muse M.D.
Address St. Agnes Hosp. Date signed 4/6/44

15997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 15997

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Altoona
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle O'Neil

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Harry O'Neil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-91

8. AGE: Years	Months	Days	If less than one day
52	3	9	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robt Lafferty
13. Birthplace Virginia

MOTHER
14. Maiden Name Maria Jane
15. Birthplace Pennsylvania

16 (a) Informant Boyd E. Shultzaberger
(b) Address 111 E. Albert Court
17 Removed (b) Date thereof 4/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Calvary
Location Altoona Pa.
18 (a) Funeral director Wilhelm Loeb Co
(b) Address 1219 E. Pratt St
19 APR 10 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 44, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 19 44 to 4-9 19 44, and that I last saw h.e. alive on 4-1 19 44.

Immediate cause of death (a) Carcinoma of Breast

Due to (b) Metastasis

Due to (c)

Other Conditions Myocardial degeneration
Carcinoma
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Clinical Diagnosis

Duration
(a) 4 days
(b)
(c)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Culley M. D.
Address Church Home & Hospital Baltimore, Md. Date signed 4-8-44

VS 150

15998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G 15998

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ DC (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Connect. Ave Apt 202 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Walsky

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Hospt Rec.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 9 44 (month) (day) (year)
(c) Cemetery or crematory
Location Washington DC

18 (a) Funeral director B. Danzansky
(b) Address 3501-14th St NW

19 (a) APR 10 1944 (b) Huntington Williams, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1944 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1944 to 4/9 1944 and that I last saw him alive on 4-9 1944.

Immediate cause of death Coronary failure

Due to

Due to

Other Conditions Ca of bladder

(Include pregnancy within 3 months of death)

Date of operation 4-7-44

Major findings of operation: Metastasis implant - left.

of autopsy: Ca of bladder

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Lebender M.D.
Address Sinai Hospital Date signed 4-9-44

G 15999

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

G 15999 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Fenlon ave
(c) Hospital or institution: maryland General
(d) Length of stay in Hospital or inst. (~~year, month, or~~ days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 W. Lanvale St. #16 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna M. Karcher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Henry F. Karcher
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1873

8. AGE: Years	Months	Days	If less than one day
70	6	24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

MOTHER / FATHER
12. Name Peter Mehr
13. Birthplace Germany
14. Maiden Name Augusta Fritz
15. Birthplace Germany

16 (a) Informant Hildegard Karcher
(b) Address 2417 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1215 Eutaw Pl. Huntington 0111

19 APR 10 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1944 at 8 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1944 to 4-9 1944, and that I last saw her alive on 4-9 1944.

Immediate cause of death Pulmonary Embolus — Duration

Due to Carcinoma of rectum & colostomy

Due to

Other Conditions Arteriosclerosis & Pregnancy (Include pregnancy within 3 months of death)

Date of operation 3-17-44

Major findings of operation: Carcinoma of rectum & obstruction

of autopsy: None

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Young Jr. M. D.
Address Md Gen. Hosp Date signed 4-9-44

VS 150

G 16000

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G 16000
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 N. 30th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 332 N. 30th Street (Rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country England

3 (a) FULL NAME Mrs. Elizabeth Tyson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James Tyson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4-1877

8. AGE: Years 66 | Months 4 | Days 3 | If less than one day: hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Geo. Duckitt
13. Birthplace England

MOTHER
14. Maiden Name Mary Crimmingham
15. Birthplace England

16 (a) Informant James Tyson
(b) Address 332 N. 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11-1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9- 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2- 1943 to 4-8 1944.
and that I last saw her alive on 4-8 1944.

Immediate cause of death Cancer of right breast
Metastases to Skull
Due to
Due to Duct cell carcinoma
Other Conditions

Duration 3 years

(Include pregnancy within 3 months of death)
Date of operation 3 years ago
Major findings of operation: Cancer of Breast (Right)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. E. Sullivan M. D.
Address 11 E. Chase St Date signed 4-12-44

VS 150

G 16001 6 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 16001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 E. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANSEL LEE RICH

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 212-16-8564

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	W	Married

6 (b) Name of husband or wife: Tillie Rich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 12, 1896

8. AGE: Years	Months	Days	If less than one day
47	11	26	hr. min.

9. Birthplace: Norfolk Va (Town, county, and state)
10. Usual Occupation: Shipmoor
11. Industry or business: Bethlehem Fairfield Shipyards

FATHER
12. Name: Albert S Rich
13. Birthplace: Mass

MOTHER
14. Maiden Name: Tillie Cox
15. Birthplace: Crisfield Md

16 (a) Informant: Mrs Tillie Rich
(b) Address: 417 E 21st St
17. Burial, cremation, or removal: Luna (b) Date thereof 4/11/44 (month) (day) (year)
(c) Cemetery or crematory: Mowland Park
Location: Baltimore Co Md
18 (a) Funeral director: Tillman Funeral Home Inc
(b) Address: 1219 E Fort Ave
19 APR 10 1944 (b) Huntington Williams, M.D. (Date accepted for registration) (By the city registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944 at 9 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Williams M.D.
Medical Examiner
Date signed 4-7-44

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

G 16002
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sallie Frances KRUGS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband ~~or wife~~ Walter Krugs
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Feb 1 1871

8. AGE: Years	Months	Days	If less than one day
73	2	27	... hr. ... min.

9. Birthplace Hagerstown, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Silas Davis
13. Birthplace Williamsport Md

MOTHER
14. Maiden Name Sarah V. Staley
15. Birthplace Williamsport, Md

16 (a) Informant Walter Krugs
(b) Address 408 W. Mulberry St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof Apr. 10, 44 (month) (day) (year)
(c) ~~Cemetery or crematory~~ New Cathedral
Location Baltimore, Md

18 (a) Funeral director Wm. Cook Inc
(b) Address 127 St. Paul St

19 (a) ~~Date received by registrar~~ APR 10 1944 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944, at 1:42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 22 1943 to April 8 - 1944, and that I last saw her alive on April 6 1944.

Immediate cause of death	Duration
Lobar pneumonia	unknown
Due to	
Due to	
Other Conditions Arthritis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chester Rideout M. D.
Address 212 E Edmondson Ave Date signed April 8 1944

G 16003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 16003 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3627 Roberts Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Stemmers Run
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ameran Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Lange

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Sarah Lange
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 1862

8. AGE: Years	Months	Days	If less than one day
82	2	6	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name (Unknown) Lange
13. Birthplace Md

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Bessie L. Browning
(b) Address 3627 Roberts Place

17 (a) Burial (b) Date thereof 4, 11, 44
(Burial, ~~cremation or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) APR 10 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1944 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20- 1944, to 4-7- 1944
and that I last saw h alive on 3-27 1944.

Immediate cause of death	Duration
(a) Coronary Thrombosis	
Due to (b) Arteriosclerosis	
Due to (c) Cardiovascular Disease	
Due to (d) Arteriosclerosis	

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Cochrane M.D.
M. D.
Address 37 E Cowling St Date signed 4-8-44

Boardman

16004 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 16004

CERTIFICATE OF DEATH

94a

1. PLACE OF DEATH N.E.

Registered No.

CITY OF BALTIMORE: (No. 23rd & St Paul St. V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Dorie Elizabeth Ann Crum

If U. S. Veteran specify WAR

(a) Residence: No. 3120 Abell Ave St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a. If married, widowed, or divorced (HUSBAND of) (or) WIFE of William Crum

6. DATE OF BIRTH (month, day, year) Sept 13th 1885

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	6	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. At Home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Stewartstown Pa.

FATHER

13. NAME Jeremiah Waltemeyer

14. BIRTHPLACE (city or town) (State or country) Stewartstown Pa.

MOTHER

15. MAIDEN NAME Kezia A. Kedrick

16. BIRTHPLACE (city or town) (State or country) Pa

17. INFORMANT Wm Crum

(Address) 3120 Abell Ave

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Druid Ridge Date April 13 1944

19. UNDERTAKER William Cook Inc.

(Address) 2117 St. Paul St.

20. FILED APR 10 1944 19 Huntington Williamsworth

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 7, 1944

22. I HEREBY CERTIFY, That I attended deceased from March 29, 1944 to April 7, 1944

I last saw her alive on April 5, 1944 Death is said to have occurred on the date stated above, at 2:30 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	April 7 1944
Bronchial pneumonia	April 1 1944
bilateral	

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) Harry S Bach M. D.

(Address) 100 E. 22nd St Apt 6

Balto

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

G 16005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 16005 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 519 Dennison St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 519 Dennison St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antonio Lorenzo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband~~ wife Philomena Lorenzo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 7 1860

8. AGE: Years	Months	Days	If less than one day hr.	min
84	1	2		

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Fruit Dealer

FATHER

12. Name Tomaso Lorenzo

13. Birthplace Italy

MOTHER

14. Maiden Name Rose (Raimondi)

15. Birthplace Italy

16 (a) Informant Philomena Lorenzo

(b) Address 519 Dennison St

17 (a) Burial (b) Date thereof 4/11/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto. Md

18 (a) Funeral director William Sokolic

(b) Address 1213 St. Paul St

APR 10 1944 (b) Huntington, West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1944, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 19 1944 to Apr 7 1944 and that I last saw h~~im~~ alive on Apr 7 1944

Immediate cause of death: Cerebral Hemorrhage — Duration 3 hrs.

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph L. Volentine M.D.

Address 732 N. Rosedale Date signed 4/8/44

16006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 16006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2031 E. 32nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2031 E. 32nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma M. Sterling

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Wm Edw. Sterling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14th, 573

8. AGE: Years	Months	Days	If less than one day
66	0	23	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name James Henry Canoles
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Emma Susan Matilda Jackson
15. Birthplace Pa.

16 (a) Informant John A. Knight
(b) Address 2031 E. 32nd St.

17 (a) Burial (b) Date thereof 4/10/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Woodlawn Md

18 (a) Funeral director Wm Cook, Inc
(b) Address 1217 St. Paul St.

APR 10 1944 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1944 to 4/7 1944 and that I last saw h~~im~~ alive on 4/7 1944.

Immediate cause of death Paralysis — Duration 3 days

Due to

Due to

Other Conditions High Blood Pressure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: X

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? X
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Hearn M.D.
Address 790 Tarrymore Blvd Date signed

16007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 16007

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamilton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Govans (If outside city or town limits, write RURAL and give town)
(d) Street No. 5[illegible] York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Schmuff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mar 25th 80

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 28th 80

8. AGE: Years 83 | Months 0 | Days 4 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Baker

FATHER
12. Name (Unknown) Schmuff
13. Birthplace "

MOTHER
14. Maiden Name Annie (Unknown)
15. Birthplace "

16 (a) Informant Miss Anna Schmuff
(b) Address 5217 York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1212 St. Paul St

19 (a) [illegible] Huntington Williams, M.D.
(b) Address 524 York Rd

APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1944 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1944 to April 7 1944 and that I last saw him alive on April 7 1944

Immediate cause of death: Hypertension and Cardio-vascular disease
Due to senility.
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 7

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature [illegible]
Address 524 York Rd Date signed 4/8/44

VS 180

G 16008

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

Registered No. G 16008

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 W. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank R. Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of ~~husband~~ or wife Ruth B. Carter
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr) Feb 2, 1892

8. AGE: Years	Months	Days	If less than one day
57	1	15	hr min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Telephone Lineman
11. Industry or business Bell Tel. Co. Balto. Md.

FATHER
12. Name Franklin Carter
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Laura (Unknown)
15. Birthplace Balto. Md.

16 (a) Informant Ruth B. Carter
(b) Address Balto. Md.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4 10 47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Baltimore Md.

18 (a) Funeral director William Cook Inc.
(b) Address 21 E. Saint Paul St

19 (a) APR 10 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 19 47, at 4:20 P M

21. I certify that I took charge of the remains described above, held an Inquiry — A-947 - Marine Hospital Pathologist Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions Arteriosclerotic Cv disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/29/47 at 10 AM M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Fell out of bed

23. Signature Charles F. Fahrner M.D.
Medical Examiner
Date signed 4/7/47

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 16009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

G 16009
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette + Eutaw Sts
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2630 N. Charles St. Baltimore Highlandtown
(If outside city or town limits, write "Rural" and name of town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr William C. Winthicum

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	wh.	divorced

6 (b) Name of husband or wife Helen Perry Winthicum
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 12/18/93

8. AGE: Years	Months	Days	If less than one day
50	4	19	..... hr. ..... min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Clerk Court House
11. Industry or business Register of Wills

FATHER
12. Name Wm. Winthicum
13. Birthplace Maryland (A.M.Co)

MOTHER
14. Maiden Name Adela Knight
15. Birthplace Balto Md.

16 (a) Informant Laura L. Herzog
(b) Address 2630 N. Charles St.

17 (a) Burial (b) Date thereof 4-10-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore-National
Location Baltimore Md

18 (a) Funeral director Geo. L. Dieffer Jr
(b) Address 1512 Hollins St

19 (a) APR 10 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944, at 3 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1944 to 4/7 1944, and that I last saw h / M alive on 4/7 1944.

Immediate cause of death Bronchiogenic Carcinoma [redacted]

Due to

Due to

Other Conditions Hemorrhagic Anemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: — Same.

Duration
?

Zuelzer
PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Jr Krieg M.D.
Address Bon Secours Hosp Date signed 4-7-44

VS 3

G 16010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

G 16010 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1738 E Federal St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Krastel

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife Phillip J. Krastel
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 4-6-1870

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	0	2		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wesley Forsuch
13. Birthplace Md

MOTHER
14. Maiden Name Mary Harmon
15. Birthplace Md

16 (a) Informant Phillip J. Krastel
(b) Address 1738 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Wendell E. Humphreys
(b) Address APR 10 1944 W. Broadway

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1944, at 2:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from March 29th 1944 to April 7 1944, and that I last saw her alive on April 7 1944.

Immediate cause of death, Myocarditis — Duration 12 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature

Address Baltimore, Md. Date signed 4-8-44 M D

G 16011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 16011 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3412 Mondawmin Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Mondawmin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rabbi Hyman Samuel Wiener
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Esther Baila
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861
8. AGE: Years 83 | Months | Days | If less than one day hr min

9. Birthplace Russia (Town, county and state)
10. Usual Occupation Rabbi
11. Industry or business

FATHER 12. Name Moses
13. Birthplace Russia

MOTHER 14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Rw
(b) Address

17 (a) Burial (Burial, cremation, or removal) Date thereof 4-10-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E. Baltimore St

APR 10 1944 Registrar Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9-1944 at 1:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 2/30 19 , to 4/8/44 and that I last saw h/ alive on 19

Immediate cause of death Coronary Occlusion — Duration 2 yrs

Due to Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work?)
(e) Means of injury

23. Signature Maurice Schloss M.D.
Address 2225 Linden Ave Date signed 4/9/44

16012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. G 16012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 Ensor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
a. State Md b. County
c. City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
d. Street No. 710 Ensor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelia Ellis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1888

8. AGE: Years: 55 | Months: 7 | Days: — | If less than one day: hr min

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Edward Robinson
13. Birthplace Unknown

MOTHER 14. Maiden Name Charlotte McElderry
15. Birthplace Md.

16 (a) Informant Arthur Johnson
(b) Address 710 Ensor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location

18 (a) Funeral director Mrs. Robert A. Elliott Dpt
(b) Address 1109 N. Carlton St.

19 APR 10 1944 (Date received by Registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4·6 1944 at 9 30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11/ 1943 to 4/6/ 1944
and that I last saw h e r alive on 3/25 1944

Immediate cause of death: Carcinomatosis — Duration: 15 mos

Due to Carcinoma of stomach

Due to

Other Conditions Hypertensive cardio-renal disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the name to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Yes or No)
(e) Means of injury
23. Signature [signature]

Address 1500 E Madison St Date signed 4/8

Rayner Browne

16013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 16013
Registered No.

1 PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 E. Chase St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Guy
3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 13, 1861
8. AGE: Years 83 Months 2 Days 24 If less than one day hr min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George F. Guy
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Elizabeth Klein
(b) Address 2006 E. Chase

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North & Milton Ave

18 (a) Funeral director Howard N. Blight
(b) Address 4914 Belair Road

19 (a) (Signature of registrar) Huntington Williams, M.D.

APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943, to April 7 1944, and that I last saw her alive on April 7 1944

Immediate cause of death: Chronic Myocarditis — Duration: 6 yrs

Due to: Chron. Diabetes Mellitus — Duration: 15 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause, to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Ayd
Address 2006 E. Monument St Date signed 4/8/44 M. D.

Please fill in all items, if unknown, state "unknown". Physicians, please write the causes of death clearly and legibly.

G 16014

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 16014

CERTIFICATE OF DEATH 93E

Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 1

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Carey St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Virginia Simpson
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-10-8401

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	widow

6 (b) Name of husband or wife
6 (c) If alive, give age— years

7. Birth date of deceased (mo., day, yr.) Aug 23 1890

8. AGE: Years	Months	Days	If less than one day
53	7	15	hr. min.

9. Birthplace Maryland (Baltimore)
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Pernell Simpson
13. Birthplace unknown

MOTHER 14. Maiden Name Isabella Collins
15. Birthplace Baltimore Md

16 (a) Informant Mrs Etta Blackwell
(b) Address 1113 Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, '44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7- 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4- 1944, to 4-7-1944 and that I last saw her alive on 2-6- 1944

Immediate cause of death: Myocarditis — Duration: unknown

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 4-7-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93P

G 16015 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Lindsay,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Lindsay,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4.1850

8. AGE: Years	Months	Days	If less than one day
93	8	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John McDOnald,
13. Birthplace England,

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant John M. Lindsay,
(b) Address 406 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11.1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Robert S. Little,
(b) Address 2700 Edmondson Ave

19 (a) (b) Registrar

APR 10 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH APR 7 1944 19 , at 1145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1944 to April 7 1944 and that I last saw h[illegible] alive on April 7 1944

Immediate cause of death Myocardial insufficiency Arterio sclerotic Hypertension

Due to chronic

Due to Generalized arterio sclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: General Gen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Mitchell M. D.

Address 701 Edmondson Ave Date signed April 14

G 16016

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92D

G 16016
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd
(c) Hospital or institution:
Harford Convelescent Home
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5219 Harford Rd
(If rural, give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Leona E. Finnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Reuben
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1870

8. AGE: Years	Months	Days	If less than one day: hr.	min
74 yo	1	19		

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Everhard Hartke
13. Birthplace ?

MOTHER
14. Maiden Name Anne C
15. Birthplace ?

16 (a) Informant Mrs Phillip Capocci
(b) Address 5219 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month, day, year) 4-[illegible]-44

(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Leonard Hunt
(b) Address 5305 Harford Rd

19 (a) (Date received by registrar) (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944, at M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1 1943 to 4/7 1944 and that I last saw h[illegible] alive on 4/7 1944

Immediate cause of death Hypertensive Cardio-Vascular Disease

Duration

Due to

Due to

Other Conditions

(Include conditions which gave rise to immediate cause of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature [illegible]
Address 5703 Harford Rd Date signed 4/10/44
M.D.

16017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16017
Registered No.

160a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 So. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Pt 19 Md
(If outside town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Imai

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced** —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1944

8. AGE: Years | Months | Days | If less than one day 5 hr 15 min

9. Birthplace Baltimore Md. St. Joseph Hospt.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER
12. Name George Imai
13. Birthplace Balto
14. Maiden Name Josephine Kemer
15. Birthplace Balto.

16 (a) Informant George Imai
(b) Address Sparrows Point, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-44 (month) (day) (year)
(c) Cemetery or crematory Oak Grove
Location Balto Md

18 (a) Funeral director Frank Brockus
(b) Address 1100 N. Chester St

APR 10 1944
(Date rec'd by registrar) Registrar

VS 160

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944 at 8:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Apr 9 1944 to Apr 9 1944, and that I last saw h[illegible] alive on Apr 9 1944

Immediate cause of death Cerebral Hemorrhage — Duration 5 hrs.

Due to Ruptured Tubal Pregnancy.

Due to Continued Pelvic Hemorrhage.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
I underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Myrtle K. Janowski M. D.

Address St. Joseph's Hospt. Date signed Apr 9, 44

6018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G 16018
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Arlington ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Berry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Evelyn

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-30-1898

8. AGE: Years 45 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Berry

13. Birthplace Md

MOTHER 14. Maiden Name Julia Lancaster

15. Birthplace Va

16 (a) Informant Evelyn Berry

(b) Address 917 N. Arlington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 11 47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location B. C. County Md

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna. ave

19 (a) APR 10 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944 at 10 4x M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 19 44 to April 7 19 44 and that I last saw him alive on April 7 1944.

Immediate cause of death
Hypertension

Due to

Due to

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo Banquer M. D.
Address Primary Hospital Date signed 4/8/44

VS 180

G 16019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G 16019

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2601 Roslyn Avenue

(c) Hospital or institution: Mrs. Orrison's Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-Mos.

(e) Length of stay in Baltimore (yrs., mos., or days) abt. 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 903 McKewin Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Estelle Sophia Hollifield Walters

3 (b) If veteran, name war ----

3 (c) Social Security Account No. -------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) April 29-1865

8. AGE:

Years	Months	Days	If less than one day
78	11	10	hr ____ min

9. Birthplace Hollifield, Howard Co. Md. (Town, county, and state)

10. Usual Occupation Retired School Principle

11. Industry or business Baltimore Co. Schools

MOTHER / FATHER

12. Name Benjamin Fletcher Walters

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Laura Ruth Hollifield

15. Birthplace Hollifield, Md.

16 (a) Informant Estelle S. Hollifield Walters

(b) Address 2601 Rosyln Ave. Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-11-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore-Maryland

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (M. F. MOWEN SUC.) 108 W. NORTH AVENUE

19 (a) APR 10 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 8 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1920 1944 to Apr 8 1944 and that I last saw her alive on Apr 7 1944

Immediate cause of death: Carcinoma of bladder metastasis to liver

Duration 6 mos

Due to Stroke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature N. G. Yount M. D.

Address 2818 W Fort Ave Date signed 4-9-44

G 16020

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 146E

G 16020
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 E. 39½ St.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 E. 39 St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Annie Beaton Wilkins
3 (b) If veteran, name war none
3 (c) Social Security Account No. none
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Dr. Geo. L. Wilkins
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr) Dec 2/1869
8. AGE: Years 74 Months 4 Days 6 If less than one day hr min.
9. Birthplace Phila-Pa.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business none
FATHER 12. Name Robt T. Beaton
13. Birthplace Scotland
MOTHER 14. Maiden Name Agnes Knox
15. Birthplace Scotland
16 (a) Informant Dr. Lawson Wilkins (son)
(b) Address 501 Edgevale Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn
18 (a) Funeral director Shivers Mortuary
(b) Address 108 W. Mount Ave.
19 (a) (Date rec'd by registrar) APR 10 1944 (b) Huntington W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944 12 40 P. M
21. I certify that death occurred on the date above stated, that I attended deceased from Feb 4 1944 to April 8 1944, and that I last saw h[illegible] alive on April [illegible] 1944.

Immediate cause of death
Carcinoma of Colon — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul L. Kamman M. D.
Address 9 E. Chase St Date signed Apr. 9/1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G 16021

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 751 W. Cross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 751 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY G. BING

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine E. Bing
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1870

8. AGE: Years	Months	Days	If less than one day
73	4	13	hr min

9. Birthplace Catonsville, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Valentine Bing
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Rentz
15. Birthplace Md.

16 (a) Informant Mrs. Catherine E. Bing
(b) Address 751 W. Cross St.

17 (a) Burial (b) Date thereof 4/ /44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 10 1944
(Date rec'd by registrar) (b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8, 1944, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1944 to Apr. 8 1944
and that I last saw h~~im~~ alive on Apr. 7th 1944.

Immediate cause of death — Duration

Due to Prostatic Hypertrophy and Uremia. — 2 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry H. Cater

Address 517 Scott St. Date signed 4/8/1944

G 16022

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G 16022
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 W. Belvedere Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 W. Belvedere Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1858

8. AGE: Years	Months	Days	If less than one day
86	1	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Moses Johnson
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Logan
15. Birthplace Ireland

16 (a) Informant Mrs. Annie R. Kroeger
(b) Address 3500 W. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave. Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Ave. Balto. Md.

19 (a) (Date rec'd by Local Registrar) Registrar

APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 1937 to 4/7 1944
and that I last saw h alive on 4/5 1944.

Immediate cause of death was exhaustion from atelectasis of both lungs & pneumonia
Due to Blood supply & tissues failed to be properly oxygenated.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry S. Cornell
Address 3902 Groveland 15 Date signed 4/8/44

G 16023

71473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 D

G 16023
Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 2- 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Jackson St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Yeakel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1875

8. AGE: Years	Months	Days	If less than one day
67	4	25	hr min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None Sheet metal w.
11. Industry or business Work National Enameling

FATHER
12. Name James Yeakel
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Metzger
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Bedan Hill
Location Balto

18 (a) Funeral director A. Howard Evans
(b) Address 14 W Saratoga

19 (a) Date received (month) (day) (year) Huntington Williams, M.D. Registrar

APR 10 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1944 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 4/7 1944 and that I last saw him alive on 4/7 1944.

Immediate cause of death Multiple small cerebral hemorrhages of infants. Duration 2 /

Due to H.C.V.D.

Due to

Other Conditions Left hemiplegia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes or No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sergeon M.D.
Address B C H Date signed 4/8

G 16024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16024 Registered No. 109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Lyon St
(c) Hospital or institution: South East Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1446 S Charles St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Mae Settlemires

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-44

8. AGE: Years	Months	Days	If less than one day
0	2	3	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER
12. Name Ellis Settlemires
13. Birthplace Oklahoma

MOTHER
14. Maiden Name Margaret Debro
15. Birthplace Balto. Md

16 (a) Informant Sophia Debro
(b) Address 1446 S Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto

18 (a) Funeral director A. Howard Evans
(b) Address 1440 S Charles St

19 (a) 1944 (Date) (b) Huntington Williams, MD (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1944 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1944 to 4-9 1944
and that I last saw h e r alive on 19

Immediate cause of death Anoxia

Due to Pneumonia

Due to

Other Conditions dehydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. Brooke Wilson Jr M. D.
Address South East Gen Hosp Date signed 4-9-44

G 16025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G 16025 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 McCulloh
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 McCulloh
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Thomas Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Bl

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1878

8. AGE: Years 70 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Laborer

FATHER 12. Name Collin Rogers

13. Birthplace Md

MOTHER 14. Maiden name Margaret Gist

15. Birthplace Md

16 (a) Informant Mrs Blanche Rogers

(b) Address 1708 McCulloh

17 (a) Burial (b) Date thereof 2-13-1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md.

18 (a) Funeral director Mrs. George W. Holland

(b) Address 1631 Druid Hill Ave

19 (a) APR 10 1944 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/44 19 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7/43 to 2/5/44 19 ; and that I last saw him alive on 2/1/44 19

Immediate cause of death (a) Pulmonary Thrombosis

Contributory Cause

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Williams

Address 734 Mosher Ave Date 2/5/44

M. D.

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16026 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 Andrea Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days) 33 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Andrea (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Pomroff

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4670

MEDICAL CERTIFICATION 1015

20. DATE OF DEATH April 4 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1944 to April 4, 1944. that I last saw him alive on 4-3, 1944.

Immediate cause of death: Chronic Myocardial Degeneration — Duration: 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Stanislawa Pomroff
6 (c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) aug 5 1888
8. AGE: Years 55 Months 7 Days 29 If less than one day hr. min.
9. Birthplace poland (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Joseph Pomroff
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Wyrobels
15. Birthplace Poland

16 (a) Informant Mrs. Stanislawa Pomroff
(b) Address 1414 andre Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 461 S. Chester Street

19 (a) APR 10 1944 Registrar
Huntington Williams, M.D.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 707 E. Fort Ave. Date signed 4-5-44

Correct age is especially important. If veteran, please write the causes of death clearly and legibly.

VS 150

G 16027

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 458

G 16027 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

15 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3226 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Joseph W. Whiteford

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary A. Rusker
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) June 16, 1866

8. AGE: Years	Months	Days	If less than one day
77	9	23	12 hr. min

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Salesman - retired
11. Industry or business

FATHER
12. Name John Whiteford
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Virginia Pledge
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Roberta W. King
(b) Address 3226 Gwynn's Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, '44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1943 to April 8 1944.
and that I last saw him alive on April 5 1944.

Immediate cause of death Carcinoma of tongue — Duration about 5 mo

Due to

Due to

Other Conditions Carcinoma of tongue — about 5 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Hall & Tibbals M. D.
Address 2220 Garrison Ave. Date signed Apr 8/44

G 16028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$2a

G 16028 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 Valley Street
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Valley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Weber

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Francis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Adam
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1201 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Gramercy Ave

19 (a) (Date rec'd by registrar) (b) Registrar

APR 10 1944

Director Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 4 p m M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6- 1944, to April 9 1944, and that I last saw him alive on Apr- 9- 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arteria Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 4/10/44

G 16029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G 16029 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 Seyon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. Morrell Pk (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Seyon St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Carl H Boling Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 23 1943

8. AGE: Years	Months	Days	If less than one day
	7	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Carl H Boling
13. Birthplace Tenn.

MOTHER
14. Maiden Name Juanita R Smith
15. Birthplace Tenn.

16 (a) Informant Mrs Carl H Boling
(b) Address 1806 Seyon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)
(c) Cemetery or crematory Knoxville Cem
Location Knoxville, Tenn

18 (a) Funeral director Wm M Marech
(b) Address 713 E. 34 St

19 (a) (b) Huntington Williamson W. Va. Registrar

APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 2:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1944 to 4/9 1944 and that I last saw h[illegible] alive on 4/8 1944.

Immediate cause of death: Influenzal Bronchopneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Barranco, M. D.
Address 435 Fort Ave Date signed 4/10/44

G 16030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16030
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County Baltimore
(c) City or town Franklintown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5316 Dogwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Amanda Amos

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Joseph Amos
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1870

8. AGE: Years	Months	Days	If less than one day
73	7	9	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry L. Hershey
13. Birthplace Pa.

MOTHER
14. Maiden Name Barbara McGuire
15. Birthplace Ireland

16 (a) Informant Mrs. Frank O'Hara
(b) Address 5316 Dogwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12. 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave

19 (a) (b)
Registrar
Huntington Williams, M.D.

APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944, at 11 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1944, to 4-8 1944, and that I last saw h alive on 4-8 1944.

Immediate cause of death
Cardiac Failure
Due to
Myocardial Infarction
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryan
Address St Agnes Hosp Date signed 4/8/44

16031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 16031 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Cathedral St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Cathedral St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE MARIE MINCH

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	Female	White	Widow

6 (b) Name of husband or wife William Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1859

8. AGE: Years	Months	Days	If less than one day
85	0	12	hr min

9. Birthplace Lovel, Maine (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Eastman
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Louis Yakel
(b) Address 117 Locust Dr., Catonsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)
(c) Cemetery or crematory North Cedar Hill Cem.
Location Frankford, Pa.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

APR 10 1944

VS 180

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Apr. 9, 1944 at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to April 9 1944 and that I last saw h alive on April 9 1944

Immediate cause of death Cerebral Hemorrhage — Duration 2 weeks

Due to (Final Antecedent Cause) — 5 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Pullman M. D.
Address 6 E Biddle St Date signed 4/10/44

G 16032

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16032
Registered No. 1242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Bolton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carlemon Anderson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day hr.	min.
40				

9. Birthplace New Bern N. C. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Ziggle Anderson
13. Birthplace Norway

MOTHER
14. Maiden Name Magna unknown
15. Birthplace Norway

16 (a) Informant Willis Funeral Home
(b) Address New Bern N.C.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory New Bern N.C.
Location

18 (a) Funeral director Wm Good Son
(b) Address 1217 St Paul St

19 (a) 4-10-1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944, at 3.46 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 9, 1944

G 16033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

G 16033 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Edmondson Rd. #18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Cecil J. Wiley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Katherine L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 15, 1894

8. AGE: Years	Months	Days	If less than one day hr	min.
50	1	23		

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Joseph A. Wiley
13. Birthplace Balto Md

MOTHER
14. Maiden Name Sarah L Thomas
15. Birthplace Balto Md

16 (a) Informant Katherine L Wiley
(b) Address 3711 Edmondson Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Poffey Cor

18 (a) Funeral director John C Morano
(b) Address 2010 E Baltimore St

(c) Date received by registrar APR 10 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8 1944, at 9-00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1944, to 4-8 1944, and that I last saw her alive on 4-8 1944.

Immediate cause of death	Duration
Due to Fat embolism or pulmonary	
Due to Intestinal Obstruction	6 days
Due to Post operative adhesions	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-4-44
Major findings of operation: Post op. adhesions & intestinal obstruction.
of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D Young Jr M. D.
Address Md Gen. Hosp Date signed 4-8-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16034 Registered No. 1170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1642 Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 E Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Slattery

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 17th 1875

8. AGE: Years	Months	Days	If less than one day
69 69	7	21 22	hr. min.

9. Birthplace Ireland. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Michael Slattery
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Mrs Margaret Keenan
(b) Address 1642 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Annapolis Blvd.

18 (a) Funeral director Chas. J. Dill
(b) Address 1571 E. Fort Ave

APR 10 1944

(Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 5 30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/29 1944, to 4/9 1944, and that I last saw h[illegible] alive on 4/8 1944.

Immediate cause of death: Bronchopneumonia — Duration: 9 days

Due to

Due to

Other Conditions Duodenal Ulcer — Duration: 3 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith

Address 1223 E. North Ave Date signed 4/10/44 M. D.

18035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 16035
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Typewriter ribbon should be used. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard St
(c) Hospital or institution: Universal Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Callow St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Dixon

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Baby

6 (b) Name of husband or wife Baby
6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) 2 1943

8. AGE: Years	Months	Days	If less than one day
	5 Mo		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child -
11. Industry or business

FATHER
12. Name Randolph Dixon
13. Birthplace ?, Md.

MOTHER
14. Maiden Name Sarah [redacted] Johnson
15. Birthplace ?, Md.

16 (a) Informant Sarah Dixon
(b) Address 1515 Callow St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

APR 10 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

APR 11 1944
(Date rec'd by registrar)

19 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1944, at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1944, to March 31 1944, and that I last saw him alive on March 31 1944.

Immediate cause of death: Cerebral Meningitis — Duration

Due to pneumococcic meningitis

Due to Bronco pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: NO
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Rateliff Jr. M. D.
Address Union Mem Hosp Date signed 4/7/44

VS 180

0855

16036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98

G 16036
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889 1879

8. AGE: Years	Months	Days	If less than one day hr.	min.
65				

9. Birthplace Baltimore County Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name James Taylor
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sylvania Lee
15. Birthplace Baltimore Md

16 (a) Informant James Taylor
(b) Address 2468 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location APR 10 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 11 1944 (Date rec'd by registrar) (Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27 1944, at 8 54 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22-1944, to 3-27 1944, and that I last saw h[illegible]live on 3-27 1944.

Immediate cause of death Embolism Pulmonary — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-26-44

Major findings of operation: Gangrene foot

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Hamm M. D.
Address 2077 N Carlton Date signed 4-6-44

VS 150

0854

16037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 16037
Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. Any false statement, any omission or concealment of facts, any neglect to report any death, any interment or removal without a permit, any sale of a burial lot for the purpose of interment, any neglect to correct any certificate, any violation of the Health Laws or Regulations, any of the above acts by undertaker, sexton, or other person, is punishable by fine or imprisonment, or both, under the Health Laws of Baltimore City. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 BINNEY ST
(c) Hospital or institution:

1-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 BINNEY ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country..

3 (a) FULL NAME WILLIAM ARNOLD

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	215 01 3137

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ESTELLA ARNOLD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 24 1890

8. AGE: Years	Months	Days	If less than one day
53	7	24 14	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation BUCHER
11. Industry or business MD. DRY DOCK

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant ESTELLA ARNOLD (WIFE)
(b) Address 1105 BINNEY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 12/44 (month) (day) (year)
(c) Cemetery or crematory MORELAND PARK
Location TAYLOR AVE.

18 (a) Funeral director Lillyand Zeiler INC.
(b) Address 403 S. WOLFE ST.

APR 11 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 189

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH APR. 8 19 44 at 8/44 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1944. to Apr 8 1944
and that I last saw h alive on Apr 6 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 3-2-44
Due to
Due to
Other Conditions None.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. Schumacher M. D.
Address 842 S. Eutaw Date signed 4-8-44

G 16038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

G 16038 Registered No.

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison
(c) Hospital or institution: Lesser Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Franklintown Rd (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME August Fenchel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barbara nee Feuchard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 - 1858

8. AGE: Years 85 | Months 11 | Days 02 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name Frederick Feuchard
13. Birthplace Germany

MOTHER
14. Maiden Name Federicka Benesch
15. Birthplace Germany

16 (a) Informant Barbara nee Feuchard
(b) Address 124 S Franklintown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director F. B. Serpent & Son
(b) Address 850 W. Baltimore, Md

19 (a) (Date rec'd by registrar) (b) Registrar

APR 11 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1944, at 20. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1944, to April 8 1944. And that I last saw him alive on April 7 1944

Immediate cause of death: Cardiac failure — Duration: 2 or 3 days

Due to: metastases (carcinoma) — 3 mos.

Due to: carcinoma of prostate — 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury
23. Signature Lyman Peck M. D.
Address 220 W North Ave Date signed April 11.

C 16039

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

C 16039 Registered No.

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 813 White Oak Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Kaufman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race wh

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Russia

MOTHER

14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Marvin Fletzer

(b) Address 3909 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-44 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cemetery

Location Washington Blvd.

18 (a) Funeral director Jos Levin Inc

(b) Address 1439 E Balto. St

19 (a) (b) (Date rec'd by registrar) Lucretia Williams M.D. Registrar

APR 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1944, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1944 to 4/10 1944, and that I last saw her alive on 4/10 1944.

Immediate cause of death Cardiac failure — Duration

Due to Coronary occlusion

Due to Arteriosclerotic h. dis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Aksman M. D.

Address Sinai Hosp Date signed 4/10/44

G 16040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16040 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4001 Bonnie Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Bonnie Rd (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Minnie Esther Purse

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	M.

6 (b) Name of husband or wife Sylvanus Purse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Married wife
11. Industry or business

FATHER
12. Name Meyer Lichtenstein
13. Birthplace Germ

MOTHER
14. Maiden Name Helen Sullivan
15. Birthplace Ireland

16 (a) Informant Sylvanus Purse
(b) Address 4001 Bonnie Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-44 (month) (day) (year)
(c) Cemetery or crematory Windsor Mills Rd
Location Beth Shalom Cem

18 (a) Funeral director Sagel Herris Inc
(b) Address 1439 E Balto St

19 (a) (Date rec'd by registrar) APR 11 1944 (b) Huntington Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-44 19 . at 1 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1944 to 4/11 1944. and that I last saw her alive on 4/11 1944.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arteria Sclerosis Cardio-Vascular Disease	?
Due to	
Other Conditions Diabetes mellitus	?

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Bloom M. D.
Address 606 E. Preston St Date signed 4/11/44

G 16041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 16041

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette and Calhoun St.

(c) Hospital or institution: Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 414 Woodbine Ave

(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Girl Dahlen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. 18 min.

9. Birthplace Baltimore, Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew Dahlen

13. Birthplace Italy

MOTHER 14. Maiden Name Ethel Corrigan

15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Grace Dahlen

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY APR 10 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) APR 11 1944 (b) Huntington Williams M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7-44 19 , at 7:08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7-44 19 6:50 A.M. to 4-7-44 19 7:08 P.M., and that I last saw her alive on 4-7-44 19

Immediate cause of death Asphyxia

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas Clyde Webster M.D.

Address Franklin Square Hosp. Date signed 4/9/44

VS 2

0856

G 16042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16042 ✓ 939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N. Mulberry Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Mulberry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah D. Brennan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Patrick J. Brennan

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1868

8. AGE: Years 75 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Ohio, Pa. (Town, county, and state)

10. Usual Occupation Home mgr

11. Industry or business

FATHER
12. Name John Day
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Patrick J. Brennan
(b) Address 514 N. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Fred. Rd

18 (a) Funeral director John J. Gowan Son
(b) Address 9003 Hollins Ferry Rd

19 APR 11 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10- 19 44, at 11 A. M

21. I certify that I took charge of the remains described above, held an autopsy-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulligan M.D. Medical Examiner.
Date signed 4-10-44

VS 151

G 16043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16043 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 Russell
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Russell
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sallie Gray

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Aug 1 - 1896

8. AGE: Years 47 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Calvert Co. Md
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Rag Dealer

FATHER
12. Name William Gray
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Sophie Mason
15. Birthplace Calvert Co Md

16 (a) Informant Eddie Mason
(b) Address 913 Russell

17 (a) Burial (b) Date thereof 4/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A A Co Md

18 (a) Funeral director Isaac L Bowker
(b) Address 1018 Montgomery St

19 (a) APR 11 1944 Huntington Avenue, Md Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1944 at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3 1944 to 4/7 1944 and that I last saw h alive on 4/6 1944

Immediate cause of death
acute Lobar Pneumonia — Duration 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Greenlee M. D.

Address 1122 Sea Date signed 4/7/44

G 16044 ✓ G 16044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 FAIT. AVE BALTO. MD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Fait Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME ELLA B. HAWKINS.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOWED.

6 (b) Name of husband or wife MARTIN F.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/18/1867.

8. AGE: Years 76. | Months 6 5 | Days 21 20 | If less than one day hr min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER: 12. Name TIMOTHY FEEHELEY.
13. Birthplace UNKNOWN

MOTHER: 14. Maiden Name MARY BOLAND.
15. Birthplace UNKNOWN

16 (a) Informant MRS. MARY WHITEHILL.
(b) Address 2913 FAIT. AVE BALTO MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/14/44 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL.
Location FREDERICK ROAD. BALTO MD.

18 (a) Funeral director STEPHEN J. FIALKOWSKI, Inc.
(b) Address 1000 SKENWOOD AVE BALTO MD

19 (d) APR 11 1944 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8 1944, at 9.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15 1944, to Apr. 8 1944, and that I last saw her alive on Apr. 8 1944.

Immediate cause of death: Chronic Myocarditis
Chronic Nephritis
Due to Arteriosclerosis
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

Duration

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature J. Joseph Lowney M.D.
Address 441 N. Edmondson Ave Date signed 4/10/44

VS 150

G 16045

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 16045
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1026 Sterling St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 Sterling St (If rural give location)
(e) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME DENORRIS JOHNSON HICKMAN Beard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	S. N. G. L. E.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 28, 1933

8. AGE: Years	Months	Days	If less than one day
10	9	10	hr. min.

9. Birthplace Balto; Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hoppe Beard
13. Birthplace N. C

MOTHER
14. Maiden Name Dorothy Johnson
15. Birthplace Md

16 (a) Informant Mary Hill
(b) Address 1026 Sterling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County, Md

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 30 N. Central Ave.

19 APR 11 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944 at 8 30 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular
January

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 4-8-44

(over)

VS 151

16046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

G 16046 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2435 Eastern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Kuehne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry Kuehne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 1871

8. AGE: Years 72 | Months 3 4 | Days 5 12 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name John Burk
13. Birthplace Germany

MOTHER 14. Maiden Name Josephine Brumm
15. Birthplace Germany

16 (a) Informant Miss Minnie Kuehne
(b) Address 2435 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12 44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-6 Orleans St

APR 11 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1944 at 7-a M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 2 1944 to Apr 9 1944 and that I last saw h[illegible] alive on Apr 9 1944

Immediate cause of death: Cerebral Hemorhage — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. L. Valentine M. D.
Address Date signed

April 11, 1944 132 No Howard

16047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16047
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 N Lakewood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N Lakewood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William West Shea

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth Shea
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) 06-6-1872

8. AGE: Years	Months	Days	If less than one day
71	6	3	hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation House Painter
11. Industry or business

FATHER
12. Name Geo W. Shea
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Kirby
15. Birthplace Balto

16 (a) Informant Elizabeth Shea
(b) Address 205 N Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12 44 (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetery
Location City

18 (a) Funeral director Leitch Funeral Home
(b) Address 2004 E. Orleans St

19 APR 11 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 7 1944 at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30 1944 to 4-9 1944 and that I last saw him alive on 4-8 1944

Immediate cause of death: Coronary Thrombosis — Duration —
Due to Acute Endocarditis — 9 days
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Shea
Address 2901 E. Lexington St Date signed 4/9/44 M. D.

G 16048 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G 16048

G 16048
A 2287290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County 16

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 283 W. 31st. Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James Baldwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1?-1872

8. AGE: Years	Months	Days	If less than one day
71	8	23	hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

FATHER

12. Name William Baldwin

13. Birthplace Md.

MOTHER

14. Maiden Name Sarah J. Carr

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/44 (month) (day) (year)

(c) Cemetery or crematory Delta, Pa.

Location Pennsylvania

18 (a) Funeral director Eberhardt & Donovan

(b) Address 3615-17 Eastern Ave.

19 (a) APR 1 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 1944 at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1944 to 4/9 1944 and that I last saw him alive on 4/9 1944

Immediate cause of death: Cerebral - vascular accident — Duration

Due to A.S. C.V.D.

Due to

Other Conditions ~~Nil~~ old hemiplegia left (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Jergmon

Address BCH Date signed 4/10 M D

G 16049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 16049 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry made on this certificate must be typewritten or printed in permanent ink. Physicians: please write the causes of death clearly and legibly. Be sure that information given in answer to each question is complete and correct as far as known. Underline the cause to which death should be charged statistically. Please answer every question. If none, write none. If unknown, write unknown. If not applicable, write N. A. Be especially careful that the date of birth is correct and that the age is correctly computed. Be especially careful that the name of the informant is correctly written and that his address is given. Be especially careful that the cause of death is correctly stated. Be especially careful that the date of death is correctly stated. Be especially careful that the place of death is correctly stated. Be especially careful that the name of the undertaker is correctly written and that his address is given. Be especially careful that the date of burial is correctly stated. Be especially careful that the name of the cemetery is correctly written and that its location is given. Be especially careful that the name of the funeral director is correctly written and that his address is given. Be especially careful that the date of registration is correctly stated. Be especially careful that the registrar's signature is correctly written. Be especially careful that the date of signature is correctly stated. Be especially careful that the address of the physician is correctly written. Be especially careful that the date of signature is correctly stated.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 N. Parrish St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vivian Landers.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2·10·44

8. AGE: Years	Months	Days	If less than one day
	1	29	hr. min.

9. Birthplace University Hospital, Balto. (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business —

FATHER 12. Name Mr Landers
13. Birthplace Unknown

MOTHER 14. Maiden Name Edna Purvy
15. Birthplace Unknown

16 (a) Informant Edna Landers
(b) Address 923 N. Parrish St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Balto Co.

18 (a) Funeral director Chas H. Alexander
(b) Address 907 N. Fremont St.

19 (a) (Date received by registrar) (b) 1944 Registered No.

Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944 at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4·1 1944 to 4·9 1944 and that I last saw h alive on 4·9 1944.

Immediate cause of death Suffocation

Due to Aspiration of formula

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 4/2
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Rinehart M. D.
Address University Hospital Date signed 4/12/44

G 16050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 16050 Registered No. 1220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Garner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband or~~ wife Theresa Garner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11th 1867

8. AGE: Years	Months	Days	If less than one day
76	10	22	hr. min

9. Birthplace Paterson N.J. (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business Own Business

FATHER
12. Name James Garner
13. Birthplace Ky. U.S.

MOTHER
14. Maiden Name Margaret Riley
15. Birthplace Scotstown P.Q.

16 (a) Informant Edward D. Garner
(b) Address 339 Primrose Lane, Govans

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/11/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Mary's Belto.
Location Mannadey Md.

18 (a) Funeral director William Cookman.
(b) Address 1617 St. Paul St.

19 APR 11 1944 (Date rec'd by registrar) (b) Hunting for William Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/44 at 6.25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Intestinal Obstruction

Due to

Other Conditions Scrotal Hernia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hyglus B. Daiday M.D. Medical Examiner.
Date signed 4/7/44

VS 151

16051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 R

Registered No. G 16051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2821 Miles Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Miles Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward J. Dougherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Dougherty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31, 1892

8. AGE: Years 52 | Months 2 | Days 8 | If less than one day: hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, or state)

10. Usual Occupation Pipe fitter

11. Industry or business

FATHER
12. Name Edward Dougherty
13. Birthplace Penna

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs Mary Dougherty
(b) Address 2821 Miles Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Roland P Fisher
(b) Address 2005 Park Heights Ave

19 (a) 4-11-1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944, at 9.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1944 to April 8 1944 and that I last saw ~~was~~ alive on April 4 1944

Immediate cause of death: Cardiac insufficiency and toxemia. — Duration: 14 hr.

Due to: Pulmonary tuberculosis — Duration: not known

Due to: Pregnancy florida

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roscoe H Brown M. D.

Address 2438 Maryland Date signed 4-10-44

VS 3

G 16052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56

G 16052

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3039 Northern Parkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas C Dare

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-0303

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Martha E. Dare

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 4-7-1883

8. AGE: Years 61 | Months 0 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Steam Fitter

11. Industry or business H. E. Crook, Inc.

FATHER: 12. Name E E Dare

13. Birthplace Maryland

MOTHER: 14. Maiden Name Norris, Martha

15. Birthplace Maryland

16 (a) Informant Mrs. Martha E. Dare

(b) Address 3039 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director E. W. Ramsburg

(b) Address 1005 W. Baltimore St.

19 (a) (Date rec'd by registrar) APR 11 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1941 to April 9 1944, and that I last saw alive on April 8 1944.

Immediate cause of death: Tumor of Brain, Left Frontal Lobe — Duration: 6 Mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Tumor of Brain

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vernon N Norwood M. D.
Address Church Home & Hospital Date signed April 11 1944

G 16053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G 16053
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Avenue
(c) Hospital or institution:
Hampnett Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 N. Monroe Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anthony

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 17 1870

8. AGE: Years 73 | Months 10 11 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Washington D C
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Anthony
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Unknown

16 (a) Informant Mrs. James Scheide
(b) Address 6001 Pinehurst Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Edmondson Ave. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (b) APR 11 1944 Huntingtown, Md. Address 4706 Harford Road Date signed 4/11/44

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10th, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Febr. 20 1944, to April 9 1944, and that I last saw her alive on April 9 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days

Due to Hypertensive cardio. vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. V. Harbold M.D.
M. D.

G 16054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 16054 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W Cold Spring Lane
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) All her life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Myers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Harry H Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business —

FATHER
12. Name Richard Medley
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Blvd.

18 (a) Funeral director John J Fahey & Sons
(b) Address 118 Light St

19 (a) APR 11 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 6 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1943, to April 9 1944, and that I last saw h alive on April 7 1944.

Immediate cause of death	Duration
Chronic hypocondria	
Due to	
Due to	
Other Conditions Bronchial asthma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M M Patterman M. D.
Address 7324 Reisterstown Rd Date signed 4/10/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16055 ✓ G 16055

452068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) ✓

(d) Street No. 232 N. Calhoun St. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Isaac Holbrook ✓

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-4-97

8. AGE: Years	Months	Days	If less than one day
47	3	4	hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name Isaac Holbrook

13. Birthplace Md.

MOTHER

14. Maiden Name Emma Jefferson

15. Birthplace Md.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location .....

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944 at 4 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4-1944, to 4-8-1944, and that I last saw h[illegible] alive on 4-8-1944.

Immediate cause of death

Cardiac Failure

Pneumonia

Due to Myocarditis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Myocarditis

Duration
4 days
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature H. Clarkson Hopkins M.D.

Address Johns Hopkins Hosp Date signed 4/10/44

APR 13 1944

VS. 248

G 16056

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 16056
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM D. CRAWFORD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 15 1944.

8. AGE: Years	Months	Days	If less than one day
	1	14	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Crawford
13. Birthplace Wkeas Ga.

MOTHER
14. Maiden Name Thelma West
15. Birthplace Anne Arundel Co Md.

16 (a) Informant William Crawford
(b) Address 526 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1944 (month) (day)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) (b) Registrar
(Date rec'd by registrar)
APR 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 44 at 9 30 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular
primary

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature B. L. Wallenmeier M.D.
Medical Examiner.
Date signed 4-9-44

Correct age in expensively important. Physicians: please write the causes of death clearly and legibly.

G 16057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G 16057 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert
(c) Hospital or institution: Union Memorial Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera apts Lake Drive and Linden (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Julia Mayer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	M

6 (b) Name of husband or wife Mr. Julius Mayer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7 1863

8. AGE: Years	Months	Days	If less than one day: hr.	min.
80 ?	5	3		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Joseph Weinberg
13. Birthplace ? Germany

MOTHER
14. Maiden Name Hannah Isaac
15. Birthplace ? Germany

16 (a) Informant Husband
(b) Address Riviera apts Lake Drive & Linden

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)
(c) Cemetery ~~cemetery~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral dir. Edward Sonnheim & Son
(b) Address 1902 Eutaw Place

APR 11 1944
(Date rec'd by Local Registrar) (b) Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 April 1944 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Mar 1944 to 10 April 1944 and that I last saw her alive on 10 April 1944.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Carcinoma of lung	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Wm Lill III M. D.
Address Union Memorial Hosp. Date signed 4-10-44

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G 16058

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 22a

G 16058 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 404 Hollen Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
a. State Md. b. County none
c. City or town Baltimore (If outside city or town limits write RURAL and give town)
d. Street No. 404 Hollen Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Anna Patterson Pfeltz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Daniel W. Pfeltz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1855

8. AGE: Years	Months	Days	If less than one day
88	5	17	16 hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Isaac Rhodes
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Albert F. Pfeltz
(b) Address 128 Montrose Ave., S. Orange, N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/44 (month) (day) (year)
(c) Cemetery ~~Crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1300 Eutaw Place

19 (a) APR 11 1944 (Date rec'd by registrar) Huntington Woods (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944, to April 9 1944, and that I last saw h[er] alive on April 9 1944

Immediate cause of death
(a) Coronary Thrombosis
Due to
Due to
Other Conditions Pneumonia
(Include pregnancy within 3 months of death)

Duration
(a) 2 hrs
(b) 4 days
1944

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Krahs, M. D.
Address York Rd. & Sheridan Ave. Date signed

G 16059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92E

G 16059 Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 W. Garrison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 W. Garrison Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH E. BOWERSOX

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles H.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22, 1864

8. AGE: Years: 79 | Months: 10 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Carroll Co., Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Martin Shaffer
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Reinman
15. Birthplace: Md.

16 (a) Informant: Miss Grace E. Bowersox
(b) Address: 3308 W. Garrison Ave. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/13/44 (month) (day) (year)
(c) Cemetery or crematory Location: Lorraine Cem. Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) APR 11 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1944, at 1:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1 1944 to Apr 10 1944, and that I last saw h[er] alive on Apr 10 1944.

Immediate cause of death	Duration
Paralysis apoplexy	2 hrs
Due to Myocarditis	3 mo
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Mills
Address 3726 Park Hgts Ave Date signed Apr 11 44

G 16060

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16060 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3716 Chesholm Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Chesholm Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA ENGELHARDT

3 (b) If veteran, name war --

3 (c) Social Security Account No. no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 20, 1866

8. AGE: Years: 77 Months: 9 Days: 19 If less than one day: hr min

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown Von Ratti
13. Birthplace: Germany

MOTHER
14. Maiden Name: Lena Winkelmann
15. Birthplace: Germany

16 (a) Informant: Mr. John M. Engelhardt
(b) Address: 3716 Chesholm Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)
(c) Cemetery or crematory Location: Loudon Park Cem. Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by Registrar) (b) Registrar

VS-15d

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Apr. 9, 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 27 19 44 to Apr 9 19 44, and that I last saw h er alive on Apr 9 19 44.

Immediate cause of death: Bronchial Pneumonia — Duration: 2 wks

Due to Bronchial Pneumonia — "

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles S Hewitt M D
Address 220 Warren Blvd
Date signed April 8 1944

Hunting for relatives

G 16061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16061 Registered No. 479

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1741 Abbottston St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days 9-7
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 1741 Abbottston St. (If rural give location)
e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE R. W. McCULLOH

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 717-07-7231

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr July 6, 1883

8. AGE: Years	Months	Days	If less than one day
60	9	2	hr min

9. Birthplace Balto., Md. (Town, county and state)
10. Usual Occupation Inspector
11. Industry or business P. R. R.

FATHER
12. Name Geo. W. W. McCulloh
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Canoles
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Mary E. McCulloh
(b) Address 1741 Abbottston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8, 1944, at 6:55 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 1943 to April 8 1944. and that I last saw h[illegible] alive on April 8 1944

Immediate cause of death: Cancer of Rt. Lung — Duration 12 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 1943

Major findings of operation: Cancer

of autopsy:

PHYSICIAN
I underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Edward J. Finnegan

Address 2458 Harford Rd Date signed 4/10/44

16062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

16062 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cordova Apts Bx
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (Inside city or town limits, write RURAL and give town)
(d) Street No. Lake Drive & Brookfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Winslow Fraidin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29-1938

8. AGE: Years 5 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Arthur Fraidin
13. Birthplace Balto Md

MOTHER 14. Maiden Name Corine Crowell
15. Birthplace Balto Md

16 (a) Informant Arthur Fraidin
(b) Address Cordova Apts Bx

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location East Balto St

18 (a) Funeral director Jack Lewis Inc
(b) Address 1476 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

APR 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10 1944 at 10:38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1943, to Apr 10 1944, and that I last saw him alive on Apr 10 1944.

Immediate cause of death Metastatic Sarcoma left Humerus with metastases in neck and lungs
Due to Refused by X Ray

Duration 5 mos

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar B Friedenwald M. D.
Address 16 W Lindenave Date signed 4/11/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16063
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Fait Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Fait Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Gustav C. Raddatz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Martha A. Arndt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1874

8. AGE: Years	Months	Days	If less than one day
69	11	10	hr. min.

9. Birthplace Oxford N. J. (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business

FATHER
12. Name Carl A.G. Raddatz
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Lemke
15. Birthplace Germany

16 (a) Informant Martha A. Raddatz
(b) Address 3114 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

APR 11 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 19 41 to 4/9 19 44 and that I last saw h.i. alive on 4/9 19 44.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Arteriosclerosis

Due to

Other Conditions Myocardiopathy — arteriosclerotic form
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Hoffman, M.D.
Address 3210 Eastern Ave. Date signed 4/10/44

16064 Arnold Schultz G 16064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Carolina St.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3722 E. Pratt St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Wm. Arnold Schultz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary A. Callender

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1886

8. AGE: Years	Months	Days	If less than one day
57	3	30 29	hr min

9. Birthplace Brooklyn N.Y. (Town, county, and state)

10. Usual Occupation Water Dept.

11. Industry or business City of Balto.

FATHER

12. Name not known

13. Birthplace Denmark

MOTHER

14. Maiden Name not known

15. Birthplace Brooklyn N.Y.

16 (a) Informant Wife

(b) Address 3722 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

19 (a) Date received by local registrar APR 11 1944 (b) Registrar Huntington Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944 at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1944, to 4/8 1944, and that I last saw h[illegible] alive on 4/8 1944.

Immediate cause of death	Duration
Congestion	
Heart failure	
Due to Degeneration	
Heart Disease	
Due to	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lung Abscess Renal [illegible]

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr. H. E. Wallace M. D.

Address 1400 N. Carolina Date signed 4/8/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 16065
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Joseph M. McGlone

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Margaret E. McGlone
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 25. 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
68	8	17		

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Chauffeur, Private
11. Industry or business Mr. U. K. S. Defisher

FATHER
12. Name Patrick McGlone
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Ireland

16 (a) Informant Rev. John F. McGlone
(b) Address 1532 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edward W. Conklin Son
(b) Address 924 E. Eager St.

19 (a) APR 11 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944, at 2 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1944 to April 11 1944, and that I last saw h[illegible] alive on April 11 1944.

Immediate cause of death Congestive heart failure — Duration

Due to Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J Brennan
Address St. Joseph's Hospital Date signed 4-11-44 (M. D.)

G 16066

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1170 C

G 16066
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Poppleton (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 S. Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM MEEK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1877

8. AGE: Years	Months	Days	If less than one day
66	7	1	hr. min.

9. Birthplace New Orleans (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant City Hosp.
(b) Address Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-12-1944 (month) (day) (year)
(c) Cemetery or crematory ~~Baltimore~~ Back Bay Cem.
Location ~~Forest Cem.~~ E. 16th St.

18 (a) Funeral director John G. Connolly
(b) Address 418 Eastern Ave

19 (a) APR 11 1944 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944 at 8 30 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage

Due to

Other Conditions Fracture of both legs (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-7-44 at 8:15 P. M.
(b) Where did injury occur? Eastern Ave & Anglesea
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Pedestrian struck by auto

23. Signature H. L. Wallenweber M.D. Medical Examiner
Date signed 4-8-44

Physicians: please write the causes of death clearly and legibly.

G 16067 G 16067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193 D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4334 Glenmore ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Hans Goller. (Hans E. Goller)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-01-3094

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married.

6 (b) Name of husband or wife: Minnie Goller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	7	12		

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Cloth.
11. Industry or business

FATHER
12. Name Henry Goller.
13. Birthplace Germany.

MOTHER
14. Maiden Name Dorthea —
15. Birthplace Germany

16 (a) Informant Mrs Minnie Goller
(b) Address 4334 Glenmore ave. Balt, Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co. Maryland
18 (a) Funeral director Lessan Funeral Home
(b) Address 7401 Belair Road
19 (a) (Date rec'd by registrar) APR 11 1944 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April, 10 1944 at 8.22 p M
21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1944 to April 10 1944 and that I last saw him alive on April 8 1944.

Immediate cause of death Respiratory failure.
Due to Cardiac Decompensation
Due to Arterio-Sclerotic-cardio Vascular disease.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul R. Ziegler
Address Mercy Hosp. Date signed 4/10/44 M. D.

G 16068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G 16068 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2319 Hartford Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore City (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Ries

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband~~ or wife Kathleen Ries

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 20, 1900

8. AGE: Years 73 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Glenn L. Martin Co

FATHER
12. Name John Ries
13. Birthplace Balto Md

MOTHER
14. Maiden Name Josephine Blogs
15. Birthplace Balto Md

16 (a) Informant Mrs Kathleen Ries
(b) Address 2319 Hartford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 12/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Baltimore Md

18 (a) Funeral director Philip Henrickson
(b) Address 2024 Orleans St.

19 (a) APR 11 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 1. P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2° and 3° Burns - Entire body (Accidental)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 9 1944 11 A.M.
(b) Where did injury occur? At Home - 2214 Reisterstown Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Smoking while in bed

23. Signature Hunter Williams M.D. Medical Examiner.
Date signed April 10, 1944

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16069 Wimbrough

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G 16069 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5000 Denmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Denmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Wimbrough
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-09-9211

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Sadie E. Wimbrough
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 15, 1881
8. AGE: Years 63 62 | Months 2 | Days 25 | If less than one day hr. min.
9. Birthplace Mayville, Va.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Railroad Mfg

FATHER
12. Name John D. Wimbrough
13. Birthplace Snow Hill, Maryland

MOTHER
14. Maiden Name Elizabeth Bunkley
15. Birthplace Va.

16 (a) Informant Sadie E. Wimbrough
(b) Address 5000 Denmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Young Byers
(b) Address 505 Park Heights Ave

APR 11 1944 (Date rec'd by registrar)
(b) Inventing for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 12 Mid. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1943 to 4/10 1944, and that I last saw h[illegible] alive on 4/9 1944

Immediate cause of death: Myocardial degeneration — Duration 3 yrs
Due to: Arteriosclerosis — 6 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas L. Todd M. D.
Address 735 N. Fulton Ave Date signed 4/11/44

VS 180

Tinley

16070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G 16070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4816 Norwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4816 Norwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick G. Tinley Sr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	Married

6 (b) Name of husband or wife Elizabeth B Tinley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1868

8. AGE: Years	Months	Days	If less than one day
85	9	4	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Retired Mill Man
11. Industry or business Lumber

FATHER
12. Name Frederick Tinley
13. Birthplace England.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Frederick G. Tinley Sr.
(b) Address 4816 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Forrest Byers
(b) Address 5[illegible] York Heights Ave.

19 (a) APR 11 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to April 8 1944, and that I last saw h[illegible] alive on April 2 1944.

Immediate cause of death Cardiac failure.
Chronic Nephritis.
Due to Arteriosclerosis.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Meade M. D.

Address 731 - 711 N. Wolfe St. Date signed 4/10/44

G 16071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G 16071 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4310 Stanwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 50 V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4310 Stanwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wenzelous Biebl.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4th 1866

8. AGE: Years	Months	Days	If less than one day: hr.	min.
78	7	11		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Martin Biebl
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Ehetle
15. Birthplace Germany

16 (a) Informant Cathrine Vega
(b) Address 4310 Stanwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12th 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Losch
(b) Address 1701-03 N. Patterson Park Ave

19 APR 11 1944 Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8th 1944 at 6 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1944 to April 8 1944 and that I last saw him alive on April 6 1944

Immediate cause of death — Duration

Due to Carcinoma of Rectus Muscle

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 324 N. Arlington Ave Date signed 4/10

16072

BALTIMORE CITY HEALTH DEPARTMENT G 16072 Registered No.

CERTIFICATE OF DEATH 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 N. Bond St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon P. Burrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C	W

6 (b) Name of husband or wife Sarah Burrell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 15, 1884

8. AGE: Years	Months	Days	If less than one day
60	-	24	hr. min.

9. Birthplace Charlotte Co. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wm. H Burrell
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Scott.
(b) Address 409 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Braddlegate

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

APR 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8 1944 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature [illegible] M.D. Medical Examiner.
Date signed 7/11/44

G 16073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16073
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Bedford Ave (If rural give location)
(e) Citizen of foreign country? Gilbert St. (Yes or No)
If yes, name country

3 (a) FULL NAME LORRAINE BROOKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 12, 1944

8. AGE: Years	Months	Days	If less than one day
	1	27	hr. min

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Joseph Brooks
13. Birthplace Md.

MOTHER
14. Maiden Name Pearl Williams
15. Birthplace Md.

16 (a) Informant Pearl Williams
(b) Address 613 Gilbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/44 (month, day, year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1004 Bradley Ave

19 (a) APR 11 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 5 15 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular
primary

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature H. J. Wallenmeyer M.D.
Medical Examiner
Date signed 4-9-44

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G 16074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16074 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2220 KENTUCKY AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 KENTUCKY AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIA. E. RUTHS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	DIVORCED

6 (b) Name of husband or wife FREDERICK C. RUTHS
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) APRIL-16-1872

8. AGE: Years	Months	Days	If less than one day
71	11	2524	hr. min

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name FREDERICK. W. SCHROEDER
13. Birthplace GERMANY.

MOTHER
14. Maiden Name CAROLINE ?
15. Birthplace GERMANY.

16 (a) Informant MISS SADELL. R. RUTHS
(b) Address 2220 KENTUCKY. AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-12-44 (month) (day) (year)
(c) Cemetery or crematory ST PAULS CEMETERY
Location VIOLETSVILLE. MD.

18 (a) Funeral director Mrs Chas A. G. Rohde
(b) Address 2327 EDMONDSON AVE

19 (a) [illegible] Huntington Williams Mortician

APR 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 10 1944 at 2 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3, 1944 to April 10 1944 and that I last saw her alive on April 9, 1944.

Immediate cause of death	Duration
Coronary Occlusion	7 days
Due to Arteriosclerosis	2yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert E. Fingwald M. D.
Address 613 E North Ave Date signed 4-10-44

G 16075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 G 16075 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 334 Calvert

(c) Hospital or institution: Union Memorial Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore City

(If outside city or town limits, write RURAL and give town)

(d) Street No. Wyman Pk. apts. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs. Laura S. Grieves (Laura Simpers Grieves)

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 April 1944 at 11 50 A.M.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edw W. Grieves

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) July 20 1854

8. AGE: Years 89 | Months 8 | Days 21 | If less than one day: hr. min

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Hugh B. Simpers

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden Name Elizabeth Lemm

MOTHER — 15. Birthplace Maryland

16 (a) Informant Mrs Schulteis

(b) Address Wyman Park Apts - Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-44 (month) (day) (year)

(c) Cemetery or crematory Mt Salem

Location Wilmington Del.

18 (a) Funeral director Sherbert Mower Co.

(b) Address 108 W Mt Ave.

19 (a) Harrington Williams (Informant) (b) Harrington Williams, M.D. Registrar

21. I certify that death occurred on the date above stated, that I attended deceased from 25 Mar 1944 to 10 April 1944, and that I last saw her alive on 10 April 1944

Immediate cause of death Cardiac Resp. failure

Due to Lobar pneumonia, bilateral, hypostatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. J. Van Lill M.D.

Address Union Memorial Hosp. Date signed April 10, 1944

FB 150

G 16076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 82 B

G 16076
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Same
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Laura H. Shipper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Clare J. Shipper
6 (c) If alive, give age 1 years

7. Birth date of deceased (mo., day, yr.) Nov 8th 1900

8. AGE: Years	Months	Days	If less than one day hr	min.
37	5	2		

9. Birthplace Martinsburg W. Va.
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Law

FATHER
12. Name Charles W. Shipper
13. Birthplace W. Va.

MOTHER
14. Maiden Name Zora M. Wheeler
15. Birthplace W. Va.

16 (a) Informant Clare J. Shipper
(b) Address Bainbridge Md.

17 (a) Removal (Burial, cremation or removal) (b) Date thereof 4/12/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Winchester
Location Va.

18 (a) Funeral director William Cook Inc
(b) Address 121 E. St. Paul St

19 (a) APR 11 1944 (Registrar's signature) Huntington Hollingsworth Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944 at 4:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8/44 19 to 4/10/44 19 .
and that I last saw h (im alive on 4/10 1944.

Immediate cause of death Cerebral Embolism

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Wallace M. D.
Address 1400 N. Caroline St Date signed 4/10/44

C 16077

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

(Registered No.) C 16077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 S. East ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Kraft

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Tajarna Kraft

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8th 1866

8. AGE: Years	Months	Days	If less than one day
78	3	2	hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business ~~No~~ Income

FATHER
12. Name Jacob Kraft
13. Birthplace Germany

MOTHER
14. Maiden Name Katrina Trimmer
15. Birthplace Germany

16 (a) Informant Mrs. F. A. Smith
(b) Address 2711 Brookdale Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof (month) (day) (year)

(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook
(b) Address 1219 W. Fayette St

19 (a) (Date filed by registrar) APR 1 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10- 1944, at 3 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sub-arachnoid Hemorrhage, Traumatic

Due to

Other Conditions Compound, Comminuted fracture of Left femur. Fract. of base of Sternum
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4-9-44 at 9.35 P. M.
(b) Where did injury occur? Harford Rd. & Overland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Muldain M.D.
Medical Examiner.
Date signed 4-10-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16078

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16078 Registered No. 195-E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul - 33rd St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Salvation Army 601 N. Calvert. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harry James Hodges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3rd 1908

8. AGE: Years	Months	Days	If less than one day
35	9	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Not known

13. Birthplace

MOTHER 14. Maiden Name Not known

15. Birthplace

16 (a) Informant Hospital record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/44 (month) (day) (year)

(c) Cemetery Parkwood Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) (Undertaker) (b) Huntington Williams Reg. No.

APR 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1944 to April 9 1944 and that I last saw h[illegible]live on April 9 1944

Immediate cause of death Post-operative shock — Duration 36 hrs.

Due to Fat embolism — 36 hrs.

Due to Closed fracture of left humerus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 8, 1944

Major findings of operation: Malunited fracture, left humerus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence October 1943 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Injured leaving object

23. Signature [illegible] J. Blum

Address Union Memorial Hosp (Date signed) 4/11/44 M.D.

Approved for Hugh McNally M.D. per Robert Le Gratten M.D. 4/12/44

G 16079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 16079 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2421 St Paul St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothy H Anderson

3 (b) If veteran, name war: no
3 (c) Social Security Account No: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year): Jan 9. 1915

8. AGE: Years 29 | Months 3 | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business:

FATHER
12. Name: Harry Smith
13. Birthplace: Va

MOTHER
14. Maiden Name: Ethel E Frye
15. Birthplace: Baltimore Md

16 (a) Informant: Charles Anderson
(b) Address: 2421 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/12/44 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Parkville Md

18 (a) Funeral director: Wilbur Cook Jr
(b) Address: 1217 St Paul St

19 (a) APR 11 1944 (b) Registrar
Registered by registrar: Thurlington Williams Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to April 9 1944, and that I last saw h alive on April 8 1944

Immediate cause of death: Coronary Thrombosis — Duration: ½ hour.
Due to: Myo-Carditis — 2 years
Due to: Chronic Interstitial — 4 years.
Other Conditions: Collapsed right lung — 3 years.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Herbert M. Frankel
Address 2424 St. Paul St Date signed April 7-44. M. D.

G 16080

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16080
Registered No.

Please write plainly. Use ink. Do not abbreviate. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Silver Spring
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lawrence College
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brother Meinrad Clark

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 - 1924

8. AGE: Years	Months	Days	If less than one day
19	7	29	hr. min.

9. Birthplace Louisville Kentucky
(Town, county, and state)

10. Usual Occupation Xaverian Brother

11. Industry or business

FATHER
12. Name Joseph A. Clark
13. Birthplace Kentucky

MOTHER
14. Maiden Name Bertha L. Willett
15. Birthplace Kentucky

16 (a) Informant Rev. Bro. Victorian
(b) Address 4409 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director Chas. S. Evans & Son
(b) Address 118 N. Mt. Royal Ave.

APR 11 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 19 44 at 11:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 19 44 to 4/10 19 44, and that I last saw h/ alive on 4/10 19 44.

Immediate cause of death abdominal lymphosarcoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. J. Bryan, M. D.

Address St Agnes Hosp Date signed 4/10/44

G 16081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16081 Registered No.

Please write plainly, using ink. Every item should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 E. Fairmount Ave
(c) Hospital or institution: ?

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) 5 MONTHS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Bell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Isadore Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years: 63 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Julius Kaplow

13. Birthplace Russia

14. Maiden Name Sarah —

15. Birthplace Russia

16 (a) Informant Mrs. Mildred Daniels

(b) Address 1803 E. Fairmount Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-12-44 (month) (day) (year)

(c) Cemetery or crematory New York N.Y. —

Location

18 (a) Funeral director Jack Faivus Inc

(b) Address 1438 E. Balto. St

19 (a) (b) at (Date received by registrar) Huntington Williamsport

APR 11 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-44 19 , at 1 P. M

21. I certify that death occurred on the date above-stated; that I attended deceased from Jan 19 44 to April 11 1944 and that I last saw h alive on April 11 19 44

Immediate cause of death: Coronary Thrombosis — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore L. Solomon

Address 134 S. Bway Date signed 4/11/44

G 16082
AB-87317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 B

G 16082
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Buie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Napebin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29- 1921

8. AGE: Years	Months	Days	If less than one day
21	9	11 10	hr min

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Dorsey Saunders
13. Birthplace Virginia

MOTHER
14. Maiden Name Fenie Johnson
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address Hospital Records

17 (a) Stamped (Burial, cremation, or removal) (b) Date thereof 4-12-44 (month) (day) (year)
(c) Cemetery or crematory Burr Keswick
Location Virginia

18 (a) Funeral director Rayner S Anders
(b) Address 1412 E. Preston St

19 (a) (b)
Registered here APR 11 1944 Huntington, West Virginia
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 1944. at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1944. to 4/9 1944.
and that I last saw her alive on 4/9 1944.

Immediate cause of death: Pulmonary TBC — Duration: 3 / 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seipman M. D.
Address B C H Date signed 4/10

G 16083

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registration No. G 16083

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 268 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 268 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Tosches or Toscos

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	male	White	Widowed

6 (b) Name of husband or wife late Rose Tosches
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1868

8. AGE: Years	Months	Days	If less than one day
75	9	16	hr. min.

9. Birthplace Casalvecchio di Puglie (Italy) (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Giovanni Tosches
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Luigi Tosches (Son)
(b) Address 2726 Louise Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date received by registrar) APR 11 1944 (b) Huntington Williams, M.D. Registrar

VS-3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9/44 19 , at 8:A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 1942, to 4/7 1944, and that I last saw h l m alive on 4/3, 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerosis, old age

Due to

Other Conditions Prostate (Hypertrophy)

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyman V. Warman, M. D.
Address 333 S. Ead Ave. Date signed 4/11/44

correct age is especially important. If uncertain, please write the words "or about" clearly and legibly.

G 16084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 6

G 16084

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution:

Sinai Hospital, Baltimore

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3402 Du Pont Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3 (a) FULL NAME

Salvatrice Catherine Dempsey

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-01-4026

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Joseph L. Dempsey

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 2 1915

8. AGE: Years	Months	Days	If less than one day
29	2	8	hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business W.T. Grand.

FATHER

12. Name John Serio

13. Birthplace Italy

MOTHER

14. Maiden Name Orsolina Nazzario

15. Birthplace Italy

16 (a) Informant Orsolina Serio (Mother)

(b) Address 3402 Du Pont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Rd. Bal. Md.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Morley St.

19 (a) ..... (b) .....

(Date rec'd by registrar) Registrar

APR 11 1944

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1944, to April 10 1944, and that I last saw her alive on April 10 1944.

Immediate cause of death	Duration
Respiratory Failure	.....
Due to Meningococcic Meningitis	21 days
Due to	.....
Other Conditions	.....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Alfred H. Dann M. D.

Address Sinai Hospital Date signed 4/10/44

G 16085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 16085 **Registered No.**

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 S. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~44~~ 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William J. Mc Donnell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Julia A McDonnell
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct. 5 – 1864

8. AGE: Years	Months	Days	If less than one day
79	6	4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business Tax Dept. City of Balto

FATHER
12. Name James B. McDonnell
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Ryan
15. Birthplace Unknown

16 (a) Informant Mrs Julia McDonnell
(b) Address 116 S Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hillman St

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 5 07 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 7 1944 to Apr 9 1944 and that I last saw him alive on Apr 8 1944

Immediate cause of death

	Duration
Due to myocarditis, Acute	✓
Due to dilatation of heart	✓
Due to Chronic Interstitial nephritis	✓
Other Conditions ✓	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: ✓
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm J. McDonnell M.D.
Address 12 19 Chaplain Hospital Date signed 4/10/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G 16086
Registered No.

connect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1606 N. Pont St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 N. Pont St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Hoamer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Hubert A. Hoamer
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 23 - 1888

8. AGE: Years	Months	Days	If less than one day
55	4	17 16	hr. min.

9. Birthplace York Pa. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry M. Arndt
13. Birthplace York Pa.

MOTHER
14. Maiden Name Emma M. Strickler
15. Birthplace York Pa.

16 (a) Informant Hubert A. Hoamer
(b) Address 1606 N. Pont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 - 12 - 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave. - Balto Md.

18 (a) Funeral director John C. Miller Jr.
(b) Address 2435 E. Oliver St
(c) Huntington Williams M.D.

APR 11 1944
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 9 - 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 4-9-44 and that I last saw h alive on 4-8-44

Immediate cause of death Pernicious
Due to Anemia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration
17

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 0
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Williams Jr. M.D.
Address 1606 N. Pont St Date signed 4/10/44

G 16087 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 83a

G 16087

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 641 Redwood St. Ward 4)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Maggie Winn

If U.S. Veteran specify WAR .....

(a) Residence: No. 641 Redwood St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6. DATE OF BIRTH (month, day, year) July 2 / 84

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	9	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Work

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Virginia

MOTHER FATHER

13. NAME Anderson Wingrain

14. BIRTHPLACE (city or town) (State or country) Va

15. MAIDEN NAME Patty Gill

16. BIRTHPLACE (city or town) (State or country) Va

17. INFORMANT .....

(Address) .....

18. BURIAL, CREMATION OR REMOVAL

Place Mt Olivet Date April 11 1944

19. UNDERTAKER Mrs Katie Williams

(Address) 222 N Stricker St

20. FILED APR 11 1944 . 19 ... Registrar Huntington Williams M.D.

OCCUPATION is very important. See Instructions on Back of Certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Apr 8 . 1944

22. I HEREBY CERTIFY, That I attended deceased from Mar 16 . 19 44 to Apr 8 . 19 ...

I last saw h[illegible] alive on Apr 7 . 1944 Death is said to have occurred on the date stated above, at 9-30 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
1 Hemorrhage Brain	

Other contributory causes of importance:

Was an operation performed? No Date of —

For what disease or injury?

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19 ...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Frank C. Wagner M.D.

(Address) 3027 Calvert St.

16088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B

Registered No. 16088

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland #18
(b) Street address 33rd & Calvert St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Tennent Way, O'Donnell Heights
(If rural give location)
(e) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME Harry Robert Reed Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6. 1928

8. AGE: Years	Months	Days	If less than one day: hr.	min
15	5	5		

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER — 12. Name	Harry Robert Reed Sr.
FATHER — 13. Birthplace	Pennsylvania
MOTHER — 14. Maiden Name	Margaret Virginia Todd
MOTHER — 15. Birthplace	Maryland

16 (a) Informant Mr Harry Reed Sr.
(b) Address 1413 Tennent Way, Balto. 24, Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 14, 44 (Month) (Day) (Year)
(c) Cemetery or crematory St Marks
Location Perryville, Md. Rural
18 (a) Funeral director Lee A. Patterson & Son
(b) Address Perryville, Md.
19 APR 12 1944 by Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 11, 1944 19 . at 5 35 P M
21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1944, to April 11 1944, and that I last saw him alive on April 11 1944.

Immediate cause of death Cardiorespiratory failure — Duration: months
Due to Rheumatic Heart Disease
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. B. Morris M. D.
Address U. M. H. Date signed 4-11-44

G 16089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 16089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 E. Hoffman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 E. Hoffman St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME James E. Hunter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mary E. Hunter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1867

8. AGE: Years	Months	Days	If less than one day
76	9	13	hr. min

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Foreman

FATHER
12. Name James K. Hunter
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Laura V. Cloud
15. Birthplace Balto. Md.

16 (a) Informant Mary E. Hunter
(b) Address 2023 E. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4, 12, 44 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

APR 12 1944 (Date received by registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944 at 6.20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Jul~~ 25 1944 to APRIL 9 1944, and that I last saw ~~him~~ her alive on APRIL 9 1944.

Immediate cause of death CHRONIC MYOCARDITIS — Duration 2

Due to ARTERIOSCLEROSIS — 1

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor Goldberg M.D.
Address 3100 HARFORD ROAD Date signed 4/11/44

16090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16090
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 Stinson st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 Stinson st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Strong

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 1st 1886

8. AGE: Years	Months	Days	If less than one day hr.	min.
58	0	9		

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Director
11. Industry or business News Stand

FATHER
12. Name James R. Strong
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annie V. Schumeyer
15. Birthplace Balto Md.

16 (a) Informant Mary F. Sharp
(b) Address 340 Stinson st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof April 14 1944
(month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Balto. Md.

18 (a) Funeral director William Corkran
(b) Address 217 St. Paul st

(a) APR 12 1944
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10th 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1944 to 4/11 1944, and that I last saw h e alive on 4/11 1944.

Immediate cause of death (a) Hypertension Cardio vascular disease — Duration 7 Mos

Due to

Due to

Other Conditions Cerebral hemorrhage — 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2030 Wilkens Ave Date signed 4/11/44

16091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

G 16091
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 Towson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 Towson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence May Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-0379

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Scott Wm Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31st 1891

8. AGE: Years	Months	Days	If less than one day
53	2	10	hr. min

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Sales Lady
11. Industry or business Confectionery

FATHER
12. Name John E. Hunt
13. Birthplace Md.

MOTHER
14. Maiden Name Florence V. Covell
15. Birthplace Frederick Md.

16 (a) Informant Mrs Elsie Conner
(b) Address 1214 Elm Ridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto Md.

18 (a) Funeral director William Cost Inc
(b) Address 1217 St. Paul St.

APR 12 1944

(a) Registrar Huntington Williams M.D.

YS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th 1944, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1941 to April 11 1944, and that I last saw her alive on April 10 1944.

	Duration
Immediate cause of death: Cerebral Hemiplegia	9 days
Due to: Hemorrhage cerebral	
Due to: Essential Hypertension	3 yrs ?
Due to:	
Other Conditions: Cerebral Hemorrhage	Oct 1941

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl Pass M.D.
M. D.
Address 4001 Wilkens Ave Date signed 4-12-44

16092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

G 16092
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1733 E. Baltimore St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME YANCE, Edmund

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-38

8. AGE: Years	Months	Days	If less than one day
6	3	10	hr. min

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Edmund Yance

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Catharine Williams

MOTHER 15. Birthplace Kentucky

16 (a) Informant hospital records

(b) Address

17 (a) Burial (b) Date thereof April 12-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Germon Hill Road

18 (a) Funeral director Lilly and Zeiler Inc

(b) Address 403 S. Wolfe St.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.

APR 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1944 to April 10 1944, and that I last saw h[illegible] alive on April 10 1944.

Immediate cause of death: circulatory failure — Duration: 1 week

Due to: diphtheria

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Margaret H. D. Smith M. D.

Address Sydenham Hosp. Date signed 4-11-44

G 16093 ✓ G 16093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (~~years, months~~, or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) ~~County~~
(c) City or town Balto – (If outside city or town limits, write RURAL and give town)
(d) Street No. 5130 Belair Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME ANNIE WILHELMINA MOORE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife: James M. Moore
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 20, 1869

8. AGE: Years 74 | Months 10 | Days 21 | If less than one day: ..... hr. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: H. W.

11. Industry or business

MOTHER / FATHER

12. Name: ? Apy
13. Birthplace: Germany

14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mr. Charles W. Moore
(b) Address: 1806 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/44 (month) (day) (year)
(c) Cemetery or crematory: St. Johns Cemetery-Kingsville
Location: Kingsville, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: North Ave. & Broadway

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

APR 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1944 to April 10 1944 and that I last saw h~~e~~r alive on April 10 1944

Immediate cause of death: Cerebral hemorrhage

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature: B. H. Williams M. D.
Address: Md. Gen. Hosp Date signed 4-10-44

Burlington Williams, MD

G 16094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G 16094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 S. Highland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County - - -
(c) City or town Baltimore, 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 S. Highland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MARIE VETTER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Widowed

6 (b) Name of husband or wife: Wm. Melvin Vetter
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Mar. 24. 1874

8. AGE: Years	Months	Days	If less than one day
70	0	13	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Louis D. Minch
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: ? Klinger
15. Birthplace: Baltimore

16 (a) Informant: Mr. William M. Vetter Jr.
(b) Address: 136 S. Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 12. 1944 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: North Ave. & Broadway.

19 (a) APR 12 1944 (Date received by registrar)
Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 10. 1944 at 1.50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 1 - 1943 to April 9 - 1944, and that I last saw him alive on April 9 - 1944.

Immediate cause of death: Acute Cardiac Dilatation
Due to: Pulmonary Edema
Due to: Coronary Occlusion
Due to: Chronic Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
1 day
4 wks.
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm. G. Geyer M.D.
Address 156 W. Melton Ave. Date signed 4/10/44

Spec—12-23-21—E.B.R.S.—400 Bks.

G 16095

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 16095

95c

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1731 Poplar Grove St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Frances Mc Guath

(a) Residence No. 1731 Poplar Grove St. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~. (Write the word.)

5a-If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of John Henry

6-DATE OF BIRTH (month, day and year) Feby 19, 1876

7-AGE. 68 yrs. 1 mos. 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home duties

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Cambridge, Md

PARENTS.

10-NAME OF FATHER John T. Bailey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Cambridge Md

12-MAIDEN NAME OF MOTHER. Mary E. Bailey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Cambridge Md

14- (Informant) Mrs. Ralph Baldwin

(Address) 1731 Poplar Grove St.

15- Filed APR 12 1944 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr-12.44

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1944 to April 12 1944

that I last saw h~~e~~ alive on April 11 1944

and that death occurred, on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation = 3 days

Hypertension of Heart

(Duration) yrs. mos. days

CONTRIBUTORY (Secondary) Coronary Thrombosis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marion L. Brooks M. D.

4/12/44 (Address) 606 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION~~ or REMOVAL: Greenlawn Cemetery, Cambridge Md DATE OF BURIAL. April 14, 1944

20-UNDERTAKER. John O. Mitchell Honore ADDRESS 190 Eutaw St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 16096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16096 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 252 W. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY KENNEDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife Fraulein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
46	?	?	hr. min.

9. Birthplace Iredell Co. N. C. (town, county, and state)

10. Usual Occupation Driver

11. Industry or business

FATHER
12. Name Pritchard Kennedy
13. Birthplace N. C.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace N. C.

16 (a) Informant Mrs H. Kennedy
(b) Address 2002 St. 11th St N.Y. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 (a) APR 12 19[illegible] (Date received by registrar) Registrar
Washington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944, at 10 30 AM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D.
Medical Examiner.
Date signed 4-9-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 16097 (Registered No.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Harlem ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Wilkerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1943

8. AGE: Years	Months	Days	If less than one day
	6 mo	10	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Edward Wilkerson
13. Birthplace

MOTHER
14. Maiden Name Mollie Brandon
15. Birthplace

16 (a) Informant Mollie Wilkerson
(b) Address 1714 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port Balto. Md

18 (a) Funeral director Chas H. Alexander
(b) Address 922 N. Mount St

19 (a) (b) Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11/44 19 . at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/44 19 . to 4/11/44 19 , and that I last saw her alive on 4/11/44 19

Immediate cause of death pneumonia.
b Cardiac failure

Duration: pulv

Due to

Due to

Other Conditions none.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Ratliff, Jr. M. D.
Address University Hosp Date signed 4/11/44

451769 G 16098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G 16098 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S. Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fess Monroe
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-09-6520

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Geneva
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) 2-19-04

8. AGE: Years 40 | Months 1 | Days 21 | If less than one day: hr min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Sam Monroe
13. Birthplace Alabama

MOTHER
14. Maiden Name Anna Bailey
15. Birthplace Alabama

16 (a) Informant Records
(b) Address Johns Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 14-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a.a. co md

18 (a) Funeral director James A Stamper
(b) Address 142 W Mt Royal Ave

19 (a) (b)
APR 12 1944 Huntington Maryland
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 10 1944, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 29 1944, to Apr 10 1944, and that I last saw him alive on Apr 10 1944.

Immediate cause of death Peritonitis + pneumonia — Duration 2 days
Due to Post operative
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 4/5/44
Major findings of operation: Tumor (Ca?) of colon & intussusception.
of autopsy: Peritonitis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Dickson
Address Johns Hopkins Hospital Date signed 4/11/44

G 16099 ✓ G 16099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 N.Castle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 N.Castle St. (If rural give location)
(e) If foreign born, how long in U. S. A.) years

3 (a) FULL NAME William Ochs Sr.

3 (b) If veteran, name war -----
3 (c) Social Security Account No. -------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Ochs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.26, ~~1863~~ 1873

8. AGE: Years	Months	Days	If less than one day
70	4	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Mrs.Mary Ochs
(b) Address 625 N.Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr.12/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto.Md.

18 (a) Funeral director Philip Hauf's Sons
(b) Address 2024 Orleans St.

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 12 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th. 1944 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 4-6-44 to 4-9-44 and that I last saw alive on 4-9-44

Immediate cause of death Coronary Thrombosis — Duration 3 days

Due to Sclerosis

Due to Hypertension

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury —

23. Signature Fred Burda M. D.
Address 921 N.Patterson Pk. Date signed Apr 12 44

(OVER)

G 16100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 16100 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Laurens St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Laurens St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Dyson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 19xx

8. AGE: Years | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Albert Dyson
13. Birthplace 1101 Laurens St

MOTHER
14. Maiden Name Delores Howard
15. Birthplace Balto Md.

16 (a) Informant Albert Dyson
(b) Address 1101 Laurens St.

17 (a) Burial (b) Date thereof 4/5/44
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelso
(b) Address 1303 Presstman

19 (a) Date received (year) (b)
Registrar
Huntington Williams, MD

APR 12 1944

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 9 19xx at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 9 19xx to Apr 9 19xx and that I last saw her alive on Apr 9 19xx.

Immediate cause of death: Bronchopneumonia — Duration: 5 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Tieg M. D.
Address 928 Va. Ave Date signed 4/11/44

16101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16101
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2414 Brohawn Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2414, Brohawn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Hess

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Abel M. Hess

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2 - 1880

8. AGE: Years 64 | Months 3 | Days 8 | If less than one day hr min

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Abel M Hess
(b) Address 2414 Brohawn Ave

17 (a) Burial (b) Date thereof April 13 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location a a Co Md

18 (a) Funeral director Roth & B. M. Walters
(b) Address Roth, Tucker, &c

19 APR 12 1944 Huntington Williams M.D. Registrar
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1941, to Apr 10 1944, and that I last saw her alive on Apr 10 1944.

Immediate cause of death: Arteriosclerotic Cardio Vascular Disease — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carey Rossiter M. D.
Address 1326 W Lombard St Date signed 4/12/44

G 16102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 16102 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 Gold St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Gold St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Robert Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Lucy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1873

8. AGE: Years	Months	Days	If less than one day
70 73	5	24	hr. min.

9. Birthplace Staunton, Va (State or foreign country)

10. Usual Occupation Restaurateur

11. Industry or business

FATHER
12. Name Alexander Stewart
13. Birthplace Rappin, Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Thelma L. Addison
(b) Address 610 Gold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Mrs. Laurey H. Walker
(b) Address 1647 Druid Hill Ave.

19 APR 12 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13/ 1944 to 4/8/ 1944
and that I last saw h[illegible] alive on 4/7/ 1944.

Immediate cause of death Myocardial failure

Due to Arter. sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Howell M. D.

Address 601 N. Broadway Date signed 4/12/44

VS 180

C 16103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C 16103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 S. Robinson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Grace Zitzer

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Albert L. Zitzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1852

8. AGE: Years 66 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Delbert Ly
13. Birthplace Md

MOTHER
14. Maiden Name Mollie —
15. Birthplace Md

16 (a) Informant Sylvan L. Zitzer
(b) Address 624 Allendale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto

18 (a) Funeral director A. Howard Evans
(b) Address 1400 St Charles St

19 (a) APR 12 1944 (Registered by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 10, 1944 5:00 P.M.
(b) Where did injury occur? 312 S. Robinson St
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Fell down the stairs

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 11/1944

VS 151

Correct age is especially important. If operation: please write the cause of death clearly and legibly.

G 16104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1927 Registered No. G 16104

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1822 N. Bethel St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1822 N. Bethel St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rosina Tekeck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	(Married)

6 (b) Name of husband or wife Jerome F. Tekeck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb - 19 - 1864

8. AGE: Years	Months	Days	If less than one day
80	1	21	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Ady Fleffner

13. Birthplace Germany

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant George F. Tekeck

(b) Address 1822 N. Bethel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd - Belair

18 (a) Funeral director Wm. F. Miller Sons

(b) Address 2435 E. Oliver St

19 (a) (b)

APR 12 1944 Registrar

Huntington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 10 - 1944, at 9:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to 4-10-44, and that I last saw h[illegible] alive on 4-10 - 1944.

Immediate cause of death Hypertensive + arteriosclerotic cardiovascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Stranger, M.D.

Address 1402 E. Lanvale Date signed 4-11-44

6105

JO #87366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16105

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1303 E. Lombard St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME William Henry Meyers (or) William Meyers

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-1984

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married?

6 (b) Name of husband or wife Eva?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1893

8. AGE: Years	Months	Days	If less than one day
51	3	0	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Fairfield Ship Yard

FATHER

12. Name John Meyers

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Elizabeth Comad Conrad

15. Birthplace Baltimore, Md.

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 13 44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Rd

18 (a) Funeral director Martin F. E. Dugan Son

(b) Address 37 S. Ann St.

19 (a) APR 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10. 1944. at 12:10 A

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1944 to 4/10 1944.

and that I last saw h alive on 4/10 1944.

Immediate cause of death: Lobar pneumonia — Duration 10 d.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Seigman M. D.

Address BCH Date signed 4/10

VS 150

16106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓10

G 16106
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 E Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME John Wayne Higginton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-4-37

8. AGE: Years	Months	Days	If less than one day
6	6	6	hr. min.

9. Birthplace Evarts. Ky (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Howard Higginton
13. Birthplace Rock Hole Ky

MOTHER 14. Maiden Name Eula Higginton
15. Birthplace Evarts Ky

16 (a) Informant R Kaye
(b) Address Sydenham

17 (a) Removal (b) Date thereof 4 12 44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Harlan
Location Harlan Ky.

18 (a) Funeral director Martin K. E. Dipple
(b) Address 318 S 8th

APR 12 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1944, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8 1944 to 4/10 1944, and that I last saw h / alive on 4/10 1944

Immediate cause of death: Circulatory failure — Duration: 5 days
Due to: diphtheria
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R Kaye M. D.
Address Sydenham Date signed 4/11/44

16107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16107 Registered No. 93 D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3705 S. Hanover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY J. SCHWARZMANN

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian M. Schwarzmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1874

8. AGE: Years	Months	Days	If less than one day
70	1	18	hr. min.

9. Birthplace Pittsburgh, Pa. (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Self

FATHER
12. Name Joseph Schwarzmann
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unk nown

16 (a) Informant Mrs. Lillian M. Schwarzmann
(b) Address 3705 S. Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (b)

APR 12 1944
Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 10, 1944, at 7:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1944 to April 12 1944 and that I last saw h[illegible] alive on April 9 1944.

Immediate cause of death coronary occlusion (Duration)

Due to hypertension & disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. W. Kuster M. D.
Address 502 Patapsco Ave Date signed 4/12/44

Huntington Mitchell, M.D.

G 16108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G 16108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4215 Ridgewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Ridgewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOTTIE BRADLEY PRICE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	Female	White	widow

6 (b) Name of husband or wife George O. Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1867

8. AGE: Years	Months	Days	If less than one day
76	10	9	hr min.

9. Birthplace Harrington, Del. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Bradley
13. Birthplace Del.

MOTHER
14. Maiden Name Elizabeth Watkins
15. Birthplace Del.

16 (a) Informant Mrs. Amy P. Barber
(b) Address 4215 Ridgewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
APR 12 1944
Huntingtown Maryland

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Apr. 10, 1944, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1944 to April 10 1944 and that I last saw her alive on April 10 1944.

Immediate cause of death Carcinoma of Stomach — Duration 6 mos.
Due to Generalized Arteriosclerosis — 10 days
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos J. C. Abbott M. D.
Address 45 of Liberty Heights Ave
Date signed 4-11-44

G 16109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 16109 Registered No.

G-84488

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos., 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Hargrove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1875

8. AGE: Years 68 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Walker Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha Johnson
15. Birthplace Virginia

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 4-12-44 (month) (day) (year)
(c) Cemetery or crematory Ashland Virginia
Location

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 (a) (Signature of registrar) (b) Registrar

APR 12 1944
VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1944, at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1943, to 4/10 1944, and that I last saw her alive on 4/10 1944.

Immediate cause of death	Duration
Cardiac decompensation	?
Due to Hypertensive cardio vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul McAfee
Address B.C.H. Date signed 4/11/44 M.D.

G 16110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 6

G 16110 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 ~~1113~~ N Eden (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Doris Rollins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-4-40
8. AGE: Years 3 | Months 9 | Days 7 | If less than one day hr. min.
9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Henry
13. Birthplace
MOTHER 14. Maiden Name Louise
15. Birthplace
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location D. G. Co
18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St
19 (a) APR 12 1944 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 11 1944, at 2:00 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Apr 11 1944 to Apr 11 1944 and that I last saw h[illegible] alive on Apr 11 1944.
Immediate cause of death Shock — Duration
Due to Meningitis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Unfinished - Diagnosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ellis Feer M. D.
Address Johns Hopkins Hosp Date signed 4-11-44

VS 150

Correct age is especially important. Physicians: please write the cause of death plainly.

G 16111

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G 16111
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Mercy Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert McAllister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1872

8. AGE: Years 71 yrs. | Months 11 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Commission Merchant

11. Industry or business

FATHER
12. Name Robert J. McAllister
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McCormick
15. Birthplace Pennsylvania

16 (a) Informant Mrs Annie E McAllister
(b) Address 3329 ~~Emily~~ Emley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 14 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location East North Ave

18 (a) Funeral director J. William M Marsch
(b) Address 715 Light St

19 (a) (b) Huntington Williams

APR 12 1944

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 1:00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 11, 1944

16112

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 61

G 16112
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County Fulton
(c) City or town Rural - Atlanta
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 College Park, Ga.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Viola Fitzgerald

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	M.

6 (b) Name of husband or wife William B. Fitzgerald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	8	21		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert N. Dorsey
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Lowman
15. Birthplace Maryland

16 (a) Informant William B. Fitzgerald
(b) Address College Park, Ga.

17 (a) Removal - Burial (Burial, cremation, or removal) (b) Date thereof April 13-1944 (month) (day) (year)
(c) Cemetery or crematory West View
Location Atlanta, Ga.

18 (a) Funeral director Burgee Funeral Home
(b) Address 233 Walton St.

APR 12 1944
(Date rec'd by registrar)

Huntington Williams, M.D.
(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1944 to 4/12 1944 and that I last saw her alive on April 12 1944

Immediate cause of death: Diabetic Coma — Duration

Due to Diabetes Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. R. Wallace-Brown M.D.
M. D.
Address Wilkens & Caton Date signed 4/12/44

VS 150

G 16113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G 16113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4648 Kirkwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4648 Kirkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Barnes.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Ferdinand A. Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1863

8. AGE: Years	Months	Days	If less than one day
80	11	7	hr. min.

9. Birthplace Phila, Pa. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Mrs. Mae Brown
(b) Address 271 W 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13/44 (month) (day) (year)
(c) Cemetery or crematory Springfield.
Location Sykesville, Carroll Co, Md

18 (a) Funeral director Thanouse & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) Huntington Williams, M.D. (Deputy Registrar) Registrar

APR 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1944, at 1 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1942. to April 9, 1944. and that I last saw her alive on April 9 1944.

Immediate cause of death
Acute Pulmonary Edema
Due to Mitral & aortic insufficiency
Due to Arteriosclerotic & Hypertensional cardio vascular disease
Other Conditions Carcinoma of stomach

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
24 years
since March 1942
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Thomas M. D.
Address 4690 York Rd (12) Date signed 4/10/44

G 16114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16114

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Compton Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME DOROTHE [redacted] BARANOSKI

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4/30/43

8. AGE: Years	Months	Days	If less than one day
	11	11	..... hr. ..... min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Anthony Baranoski
13. Birthplace Balto

MOTHER
14. Maiden Name Marie Manton
15. Birthplace Phila.

16 (a) Informant Anthony Baranoski
(b) Address 1005 Compton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 17 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Casimakos Sr
(b) Address 6 Dr Wash Blvd

19 (d) APR 12 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1944, at 8 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Subdural & Subarachnoid hemorrhage, spontaneous,

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Per Henry L. Wollenweber, M.D.
Medical Examiner.
Date signed 4-12-44

VS 151

For H.L. Wollenweber, by Howard J. Wollein M.D.

G 16115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16115
Registered No.

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5522 Summerfield ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5522 Summerfield ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Francis M. Livingston

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Katherine E. Livingston

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1885

8. AGE: Years 58 | Months 6 | Days 26 25 | If less than one day: hr min

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Lady Employer

11. Industry or business

FATHER
12. Name Francis Livingston
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Merrick
15. Birthplace Balto Md.

16 (a) Informant Mrs Katherine E. Livingston
(b) Address 5522 Summerfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Harford Rd.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

APR 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944, at 4.30 a M

21. I certify that death occurred on the date above stated, that I attended deceased from April 9 1944, to April 11 1944, and that I last saw h ve alive on April 10 1944

Immediate cause of death: Coronary Embolism — Duration: 2 days

Due to Myocarditis, chron. — 3 d.

Due to Chronic Sclerosis — 3 d.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Stevens M. D.
Address 2878 Harford Rd Date signed 4-11-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

Forrest age in especially important. Physicians, please

G 16116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 16116
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2437-N-Charles St.
(c) Hospital or institution: athome
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltby
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2437-N-Charles St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME William Garfoith Stone

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harriet Q. Stone

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-18-1850

8. AGE: Years 93 | Months 8 | Days 24 | If less than one day: hr. min.

9. Birthplace India (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Rev. Meade Nesbit Stone
13. Birthplace England.

MOTHER
14. Maiden Name Katherine Egan
15. Birthplace Cork-Ireland

16 (a) Informant Mrs John E. Burns-(Dtr.)
(b) Address 2437-N-Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-13/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn

18 (a) Funeral director Stewart Memorials.
(b) Address 108 W. North Ave.

19 APR 12 1944 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18/44 19 at 0 43 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 4/2 19 44 to 4/11 19 44 and that I last saw h alive on 4/11 19 44

Immediate cause of death: Pneumonia — Duration: 2 wks.

Due to

Due to — Duration: over

Other Conditions Cerebral Sclerosis

Major findings: Of operations

Of autopsy none

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur (in home, on farm, industrial place, or in public place?) While at work?
(e) Means of injury

23. Signature Luther E. Leiby
Address 0 W. Madison St. Date signed 7/24/44

VS 3

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16117

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16117 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3039 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Pfadenhauer
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 12, 1894
8. AGE: Years 50 | Months 1 | Days 29 | If less than one day: hr. min

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business

FATHER
12. Name John Pfadenhauer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Gulda
15. Birthplace Germany

16 (a) Informant Mary Schafer
(b) Address 3034 Frederick Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) Date received by registrar (b) Registrar

APR 12 1944 Huntington Williams, M.D.
VW 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10-1944 at 11.45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured dorsal vertebrae (broken neck)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20-6
(a) Date of injury 4-10-44 at 11.30 A.M.
(b) Where did injury occur? 2500 block Wilkins Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Extinguishing fire, fell down bank.

23. Signature Howard J. Wheeler M.D.
Medical Examiner
Date signed 4-10-44

Please write plainly, with pen and ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

16118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 61

G 16118 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Odenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Orabell Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife George W. Clark

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 2/17/83

8. AGE: Years 61 | Months 1 | Days 25-24 | If less than one day: hr. min

9. Birthplace Lignum, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name John Dempsey
13. Birthplace Lignum Va.

MOTHER
14. Maiden Name Betty Dempsey
15. Birthplace Lignum Va.

16 (a) Informant Eula Frank
(b) Address Odenton, Md.

17 (a) Buried (Burial, cremation, or removal)
(b) Date thereof 4- (month) (day) (year)

(c) Cemetery or crematory
Location Dorsey Md.

18 (a) Funeral director Lloyd Cissel
(b) Address Gambrills, Maryland

APR 13 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1944, to 4/11 1944, and that I last saw her alive on 4/11 1944.

Immediate cause of death: Cardiac failure with bilateral hydrothorax — Duration

Due to Coronary thrombosis

Due to Pulmonary infarction
Spleen + Kidney infarction

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Coronary thrombosis. Pulmonary infarct

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M.D.

Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45a

G 16119

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. yrs., mos., or days 34
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
a State Md b County Carroll
c City or town Westminster
(If outside city or town limits, write RURAL and give town)
d Street No. 128 Liberty
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Dora Snyder
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) [illegible]
8. AGE: Years 76 | Months 8 | Days 26 | If less than one day hr min
9. Birthplace Md (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER 12. Name William Smelser
13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden Name Susan Marker
15. Birthplace Carroll Co. Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-44 (month) (day) (year)
(c) Cemetery or crematory Krider's
Location Westminster Md.

18 (a) Funeral director Jas. Fraser Reese
(b) Address Westminster Md.

19 APR 13 1944 (Date rec'd by registrar) Interim for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1944 at 1:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 4-9 1944, to 4-12 1944, and that I last saw her alive on 4-12 1944.

Immediate cause of death: Respiratory Failure — Duration

Due to probable Ca. Brain

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-11-44

Major findings of operation: Ca. lower lip & mandible

of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address Date signed 4-12-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16120

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

56a

Registered No. G 16120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 562 Dolphin St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Beulah Bruce Porter

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Thurssa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1915

8. AGE: Years	Months	Days	If less than one day
28	9	28	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name David Bruce
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Rosa Beasley
15. Birthplace Clenton, N.C.

16 (a) Informant Rosa Bruce
(b) Address 562 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. W. Holland
(b) Address 1631 Druid Hill Ave.

(a) APR 13 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 8:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Internal and external Hemorrhage

Due to Ruptured Hemorrhagic cyst of Ovaries

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frateman M.D.
Medical Examiner.
Date signed April 10 1944

VS 151

16121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1391 Registered No. G 16121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 05 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 - 2nd Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORIS E. LLOYD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John W. Lloyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18/1914

8. AGE: Years	Months	Days	If less than one day
30		21	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Hulf
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Bertha Kinter
15. Birthplace Md.

16 (a) Informant Mr. John W. Lloyd
(b) Address 208 Bradley Lansdowne

17 (a) Burial (b) Date thereof 4/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry W. Wilkie
(b) Address #1015 Edmondson Ave

19 (a) APR 13 1944 (b) Huntington, West Virginia, [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944 at 12 noon M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Rupture of uterus

Due to Acute suppurative endometritis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed 4-9-44

Egenrieder
G 16122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 16122
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Westshire Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Roberta Rollman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/28/44

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name J. Robert Rollman
13. Birthplace Md.

MOTHER
14. Maiden Name Carolyn R. Egenrieder
15. Birthplace Mo.

16 (a) Informant Mrs. J. Robert Rollman
(b) Address 210 Westshire Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 390 Frederick Rd

18 (a) Funeral director Harry A. Wisner
(b) Address 4101 Edmondson Ave

19 (a) Date received by registrar APR 13 1944 (b) Signature Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944, at 2 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1944, to April 11 1944, and that I last saw her alive on April 10 1944.

Immediate cause of death: Pneumonia (strep)

Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M.D.
Address St Joseph's Hospital Date signed 4-11-44

Type or print all entries in capitals. Physicians: please write the cause of death clearly and legibly.

16123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. L 16123

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 N Port St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 N Port St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Florence Simpson
(b) If veteran, name war
3 (c) Social Security Account No.
4. Sex
5. Color or race Female White
6 (a) Single, married, widowed, or divorced. Married
(b) Name of husband or wife Henry L. Simpson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 9th 1872
8. AGE: Years 71 Months 8 Days 21 If less than one day hr. min.
9. Birthplace md (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER FATHER
12. Name John Hayesdaffer
13. Birthplace Md
14. Maiden Name Elizabeth Taylor
15. Birthplace Md

16 (a) Informant Henry L Simpson
(b) Address 1615 N Port St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-1944 (month) (day) (year)
(c) Cemetery or crematory Balto Mem
Location E North Ave Cft
18 (a) Funeral director Lee G. Cook
(b) Address 1744 N. Patterson Park Ave
(c) (b)

APR 13 1944
(Date rec'd by registrar)
Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10th 1944, at 6:37 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1944 to 4-9 1944.
and that I last saw her alive on 4-9 1944.

Immediate cause of death: Acute Cardiac Dilatation
Due to Auricular Fibrillation
Due to Mitral Stenosis - Auricular Fibrillation
Other Conditions Cachexia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry A. Fine M. D.
Address 11 E Biddle St Date signed 4-11-44

6a24

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 927

G 16124
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 260 Oaklie Village
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 260 Oaklie Village (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2511

3 (a) FULL NAME Minnie Schwab

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3 1878

8. AGE: Years	Months	Days	If less than one day
65	7	9	hr min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

MOTHER / FATHER
12. Name Joseph Schwartz
13. Birthplace Austria

MOTHER / FATHER
14. Maiden Name Sarah Regalbaupt
15. Birthplace Austria

16 (a) Informant Abraham Abraham Schwab
(b) Address Wilmington Del

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory New York City
Location New York

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

APR 13 1944 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944, at 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1944 to April 12 1944 and that I last saw her alive on April 12 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 mos.
Due to: Hypertensive Cardio-Vascular disease — Duration: ?
Due to:
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl Pass M. D.
Address 4001 Wilmington Ave Date signed 4-12-44

Correct age is especially important. Physicians: please write the cause of death plainly.

G 16125 ✓ G 16125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Maryland
(b) Street address
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 27 N. Glover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara Homburg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single; married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16- 1877

8. AGE: Years 66 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name John H Homburg
13. Birthplace Germany

MOTHER
14. Maiden Name Fredericka Kiasz
15. Birthplace Germany

16 (a) Informant Mrs Louise Kumpf
(b) Address 27 N Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 15 44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Sulbach Funeral Home
(b) Address 2004 E. Orleans St

19 (a) (Date rec'd by registrar) (b) Signature of Registrar

APR 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1944 at 5:30 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to here death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature H. Ly Wallenmeyer M.D. (Medical Examiner.)
Date signed April 13, 1944.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E 6

G 16126 — Registered No. 16126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 370 S Oldham
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State — (b) County
(c) City or town 370 S Oldham St (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Caroline Taylor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Wm H Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3 - 1865

8. AGE: Years 78 | Months 7 | Days 9 | If less than one day: hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name — Hasani
13. Birthplace Germany

MOTHER 14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Wm Martin
(b) Address 370 S Oldham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14th (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) (Date rec'd by Registrar) APR 13 1944 (b) Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944 (Day) (Month) (Year) at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944 to April 12 1944, and that I last saw her alive on April 12 1944.

Immediate cause of death
Malignancy of Sigmoid Colon — Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1-2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Howard Burns M.D.
Address 511 Dundalk Ave Dundalk-22nd Md
Date signed April 12 1944

C 16127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 16127 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 N.Regester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 N.Regester St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME George A.Noah

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-8500

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Elizabeth E.Dell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7 1891

8. AGE: Years	Months	Days	If less than one day
52	8	4	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Sheat metal worker

11. Industry or business Kastner & Co.

FATHER
12. Name not known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Elizabeth E.Noah
(b) Address 1816 N.Regester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway.

19 (a) (Date received by Registrar) APR 13 1944 (b) Registrar's signature Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th. 1944. at 6 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14/ 1944. to 4/11/ 1944, and that I last saw h im alive on 4/10/ 1944.

Immediate cause of death: Pleuro-Pneumonia — Duration: 9 days

Due to ----

Due to ----

Other Conditions Pleuresy — 10 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jesse W. Margaretten M.D.
Address 401 E. 25th. St.
Date signed 4/13/44.

G 16128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

✓G 16128 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 E. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE KENYON

3 (b) If veteran, name war

3 (c) Social Security Account No. 548-03-6925

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife MARIONE NOONEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 1, 1891

8. AGE: Years	Months	Days	If less than one day
52 60	9	10	hr. min.

9. Birthplace W. SPRINGFIELD MASS
(Town, county, and state)

10. Usual Occupation PHOTO. ENG

11. Industry or business

FATHER
12. Name CURTIS W
13. Birthplace MAINE

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace

16 (a) Informant CLYDE W. KENYON
(b) Address 1309 MD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day), (year)
(c) Cemetery or crematory MARVILL BRIDGE
Location HUNTINGTON MASS

18 (a) Funeral director CLARENCE F HOFFMAN
(b) Address 1639 BROADWAY Huntington Williamsville, N.Y.

19 (a) APR 13 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th 1944 at 4 35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-11-44 at about 5 P.M.
(b) Where did injury occur? 1431 N. Charles St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury fell during fist fight on sidewalk

23. Signature H. L. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 4-12-44

VS 151

G 16129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G 16129 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 E Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Garner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1897

8. AGE: Years 47 | Months 2 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant James Garner
(b) Address 1518 E Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. County Md

18 (a) Funeral director Mrs Roberts Ellwood Sr
(b) Address 1129 N. Caroline St.

19 (a) APR 13 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1944, at 2 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2.23 1944 to 4.10 1944
and that I last saw h er alive on 4.6 1944

Immediate cause of death Mitral & aortic insufficiency — Duration UNK.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond Broome
Address 1500 E. Madison St Date signed 4/11

Raymond Broome

G 16130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 B

G 16130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 Wyeth st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Wyeth st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith C. Runkles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or divorced: Widow

6 (b) Name of husband or wife William C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/1871

8. AGE: Years 73 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Liberty Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Fogle
15. Birthplace Md

16 (a) Informant William Runkles Jr
(b) Address 522 Wyeth st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/44 (month) (day) (year)
(c) Cemetery or crematory Prospect Mt
Location Md.

18 (a) Funeral director Ambrose Doc
(b) Address 414 N. Frankline rd

19 (a) (Date received by Local Registrar) APR 18 1944 (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944, at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1943 to April 11 1944 and that I last saw h-er alive on April 10 1944.

Immediate cause of death	Duration
Mitral Stenosis	3 months
Due to	
Due to	
Other Conditions Arteriosclerosis	1 year

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Morley Hoag M. D.
Address 729 Wash. Blvd Date signed 4/18/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G 16131

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Alice Peters

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced. (Write)
F	C	Married

6 (b) Name of husband or wife Elmer Durrand
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 21, 190[illegible]

8. AGE: Years	Months	Days	If less than one day
43	8	19	hr. ..... min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name David Peters
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lucy Vernon
15. Birthplace -

16 (a) Informant Mrs Everett Harrison
(b) Address 304 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location .....

18 (a) Funeral director Mrs Kates R. Williams
(b) Address 327 W Lanvale St

19 (a) APR 13 1944 (Date rec'd by registrar) Hunter for Williams M.D. Registrar

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage spontaneous

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham, M.D.
Asst. Medical Examiner.
Date signed 4-12-44

for R. L. Graham, by Howard J. Walters, M.D.

16132 ✓ G 16132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2256 Linden Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2256 Linden Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ROSE DANNENBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1887

8. AGE: Years	Months	Days	If less than one day
56	6	16	hr. min.

9. Birthplace North Carolina. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ernest Herman Dannenberg,
13. Birthplace Germany.

MOTHER
14. Maiden Name Ernestine ----------
15. Birthplace Germany.

16 (a) Informant Miss. Bettie Dannenberg,
(b) Address 2256 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/ 13/ 44. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 13 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th. 1944 at 7.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1933, to April 11 1944, and that I last saw alive on 19.

Immediate cause of death	Duration
myocardial insufficiency	5 yrs
Due to Hypertension	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1720 Eutaw Place. Date signed 4/12/44

FURNISH WHITE FOLDER, WITH UNFOLDING INFO. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V G 16133 / 316 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1914

8. AGE: Years	Months	Days	If less than one day
29	10	25	hr. min.

9. Birthplace Ellicott city (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Jones
13. Birthplace Howard Co - Md

MOTHER
14. Maiden Name Carrie Giles
15. Birthplace Howard Co. - Md

16 (a) Informant Miss Leola Jones
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) APR 13 1944 (Date received by Registrar) (b) Huntington Williams, Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944, at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1944 to April 10 1944, and that I last saw him alive on April 10 1944.

Immediate cause of death Chronic Nephritis — Duration

Due to

Due to

Other Conditions Hypertension Coma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Bagwell M. D.

Address Provident Hospital Date signed 4/14/44

G 16134 ✓ G 16134

JL -87406

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mollie Gray

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1864

8. AGE: Years	Months	Days	If less than one day
80	2	5	hr ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name John Hughs
13. Birthplace Phila.

MOTHER
14. Maiden Name Sarah Leon
15. Birthplace N. Y.

16 (a) Informant B. C. H Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof apr 4/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Belair Rd

18 (a) Funeral director Geo M. Fowler & Son
(b) Address 8/6 N Wolfe St

19 APR 13 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1944, to 4-12 1944, and that I last saw h alive on 4-12 1944.

Immediate cause of death: Arteriosclerotic Cardio Vascular Disease — Duration: ?
Due to: Gangrene Both Feet — Duration: ?
Due to: ..... — Duration: .....
Other Conditions: .....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Donald B Hebb M. D.
Address Balt City Hosp Date signed 4-12-44

G 16135

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16135 Registered No. 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 839 W. Franklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 839 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hargrove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Henderson, N. C.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name —
13. Birthplace N. C.

MOTHER
14. Maiden Name Gaines
15. Birthplace N. C.

16 (a) Informant Clara Williams
(b) Address 839 W. Franklin St.

17 (a) Burial (b) Date thereof 4/14/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) APR 13 1944
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1944, at 11:45 M

21. I certify that I took charge of the remains described above, held an Inquest-Inquisition and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester F. Julian M.D.
Medical Examiner.
Date signed 7/10/44

Instructions: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Instructions for Williams, M.D.

G 16136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 16136 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Gilmor st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Married

6 (b) Name of husband or wife Wilburn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day hr.	min.
42				

9. Birthplace NC (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joshua Thomas
13. Birthplace N.C.

MOTHER
14. Maiden Name Mariah Best
15. Birthplace N.C.

16 (a) Informant Wm Harman
(b) Address 432 N. Gilmor st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b) Registrar

APR 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1944 to 4/9 1944, and that I last saw her alive on 4/9 1944.

Immediate cause of death Acute dilatation of stomach, following supposed nasogastric intubation for

Due to chronic retroversion abscess of

Due to

Other Conditions Diabetes, hypertension

(Include pregnancy within 3 months of death)

Date of operation 4/6/44

Major findings of operation: fibroids, retroversion, adhesions, etc.

of autopsy: acute dilatation of stomach

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Lynn M. D.
Address University Hospital Date signed 4/10/44

Victor Williams M.D.

G 16137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16137 Registered No. 108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 17
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Rural - Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 W. Joppa Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Jackson SR

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27 1888

8. AGE: Years	Months	Days	If less than one day hr.	min.
56	0	15		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER
12. Name John Jackson
13. Birthplace Maryland

MOTHER
14. Maiden Name Adelaide Laughlin
15. Birthplace [illegible]

16 (a) Informant Mrs. Charles E. Jackson Jr.
(b) Address 601 N. Joppa Road Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Bartgis Bros.
(b) Address 2334 N. Charles St.

19 (a) Filed APR 13 1944 (b) Registrar [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12-1944, at 10:23 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1944, to 4-12 1944, and that I last saw him alive on 4-12 1944.

Immediate cause of death: Myocardial Failure — Duration
Due to Acute Glomerular Nephritis & Uremia
Due to Lobar Pneumonia, bilateral
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Humphreys Jr. M. D.
Address 332 E. University Pkwy. Date signed 4/14/44

G 16138

430827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 16138
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 3843 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Howard
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife Thomas Howard
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-19-77
8. AGE: Years 66 | Months 10 | Days 23 | If less than one day hr min.
9. Birthplace Md. — Crisfield (Town, county, and state)
10. Usual Occupation none
11. Industry or business

MOTHER / FATHER
12. Name William Carver
13. Birthplace Md.
14. Maiden Name Priscilla Hryden
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.
19 (a) (b)

APR 13 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944 at 5 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 11 1944 to April 12 1944 and that I last saw her alive on April 12 1944.

Immediate cause of death: Uremia — Duration: 3 days
Due to Chronic Nephritis
Due to
Other Conditions Diabetes Mellitus, Hypertension, Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert E. Farber M.D.
Address Johns Hopkins Hosp. Date signed 4/13/44

Huntington Williams, M.D.

16139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1921

G 16139
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 E Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren M MacLeod

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Bessie Peyton
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 27 1866
8. AGE: Years 77 | Months 6 | Days 16 | If less than one day: hr. 5 min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Donald MacLeod
13. Birthplace Scotland

MOTHER
14. Maiden Name Martha Smith
15. Birthplace Balto Md

16 (a) Informant Mrs. Bessie P. MacLeod
(b) Address 1706 E Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 14 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md.

18 (a) Funeral director Henry W. Rubins Sons
(b) Address McCulloh & Orchard Sts

19 (Date received) APR 13 1944 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 12 1944 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 4 1944 to Apr 12 1944, and that I last saw h[illegible] alive on Apr 12 1944.

Immediate cause of death: Myocarditis arteriosclerosis — Duration: 1 yr
Due to: Chronic nephritis — 3 yrs ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. A. Lipps M. D.
Address 442 N Patterson Pk Date signed 4/13/44

VS 150

452338 16140 BALTIMORE CITY HEALTH DEPARTMENT G 46640
CERTIFICATE OF DEATH 154a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Venezuela (b) County
(c) City or town Caobos Colon 26 (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Venezuela

3 (a) FULL NAME ESTHER MARIA GRIMALDOS

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-37

8. AGE: Years 6 | Months 3 | Days 24 | If less than one day: hr min.

9. Birthplace Venezuela (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name HERMAN GRIMALDOS
13. Birthplace Venezuela

MOTHER
14. Maiden Name CARMEN de GRIMALDOS
15. Birthplace Venezuela

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.
18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar
APR 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH APR 12 1944, at 1045 M

21. I certify that death occurred on the date above stated; that I attended deceased from APR 10 1944, to APR 12 1944, and that I last saw her alive on APR 12 1944.

Immediate cause of death Brain tumor. Post-operative oedema.

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 4/12/44
Major findings of operation: Cerebellar tumor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Crawford
Address Johns Hopkins Hosp. Date signed 4/13/44

16141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

G 16141
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution:
Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md (b) County Baltimore
(c) City or town Brooklandville (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Bellgrove Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Florence M. Hook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11 1897, 1901

8. AGE: Years	Months	Days	If less than one day
43	3	1	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Dipper

11. Industry or business

MOTHER / FATHER

12. Name Edw. A. Dasler

13. Birthplace Balto

14. Maiden Name Cath Anne Auer

15. Birthplace Baltimore

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial, cremation, or removal Burial (b) Date thereof 4/15/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Roseign Blvd

18 (a) Funeral director J. J. Dwyer Sons
(b) Address 3 W. Lexington St.

19 (a) APR 13 1944 Huntington Williams Mort
(Date rec'd by registrar)

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1944, to 4-12 1944, and that I last saw h[illegible] alive on 4/12 1944.

Immediate cause of death
Cardiac Failure
Due to [redacted] - Toxes + Quantitative Malignancy
Due to

Other Conditions Fundafloma accumulated ascites
(Include pregnancy within 3 months of death)

Date of operation 4-3-44

Major findings of operation: Biopsy - Carcinoma accumulated ascites

of autopsy: None allowed.

Duration: 40 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wallace A. Mitchell M. D.
Address Md. Gen. Hosp. Date signed 4/13/44

16142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 16142 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Trailer Camp B-11 Fairfield
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Ferguson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1944

8. AGE: Years	Months	Days	If less than one day
			7 hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Ferguson, Jr.
13. Birthplace Genova, West Virginia

MOTHER
14. Maiden Name Kathleen Mae Schultz
15. Birthplace Chillicothe Ohio

16 (a) Informant John Ferguson, Jr.
(b) Address B-11 Trailer Camp, Baltimore 23 Md.

17 (a) Burial (b) Date thereof 4/13/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross A.M.E.
Location Annapolis Road

18 (a) Funeral director Allen J. Gray Funeral Home
(b) Address 5118 Liberty Heights Ave.

19 APR 13 1944 Harrington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1944 to April 11 1944, and that I last saw her alive on April 11 1944.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul D. Lukato M. D.
Address 1213 Light St. Date signed Apr. 13, 1944

VS 150

G 16143 G 16143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 731 N. Kenwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 N. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Stokes

3 (b) If veteran, name war: World War-O

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1894

8. AGE: Years 50 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Lithuanian (Town, county, and state)

10. Usual Occupation Baylor

11. Industry or business

FATHER
12. Name Joseph Stoike
13. Birthplace Lithuanian

MOTHER
14. Maiden Name Unknown
15. Birthplace Lithuanian

16 (a) Informant Edith Manley
(b) Address 3635 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15-44 (month) (day) (year)
(c) Cemetery or crematory Mem. Gardens
Location Frederick Rd.

18 (a) Funeral director John J. McGan
(b) Address 800 E. Lake St.

19. (a) Date received by local registrar APR 13 1944 (b) Huntingtown Williamsport Md.

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1944, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.
Date signed April 12 1944.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16144

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16144 Registered No. 1102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 E. Churchill (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. Risper

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/28/42

8. AGE: Years	Months	Days	If less than one day
1	4	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John E. Risper
13. Birthplace N C

MOTHER
14. Maiden Name Juanita Faunteleroy
15. Birthplace Balto Md

16 (a) Informant Juanita Faunteleroy
(b) Address 40 E Churchill St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co., Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery St

19 (a) (b) Huntington Williams, M.D.

APR 13 1944
VS 16

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1944 to Apr 11 1944 and that I last saw him alive on Apr 11 1944.

Immediate cause of death	Duration
Emphysema. Pt.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Apr. 2, 1944
Major findings of operation: Emphysema. Pt.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Forbes M. D.
Address University Hospital Date signed 4-11-44

16145

AB-15413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16145
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Yrs- 5 Mos-2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Georgianne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1878-80?

8. AGE: Years 66-~~65~~ | Months 10 | Days 20 | If less than one day: hr min

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Reynolds
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 1, 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 1 8 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5 1944 at 2:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1928 to 4-5 1944. and that I last saw h[illegible] alive on 4/5 1944.

Immediate cause of death: Intracerebral hemorrhage

Due to: Hemiplegia

Due to:

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathe M. D.
Address B.C.H. Date signed 4/12/44

VS 180

0865

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

File No. 15928

Registered No. G 16146

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6648 Eastern Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Scotland

3 (a) FULL NAME James MacIntyre

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1 1861-1862

8. AGE: Years	Months	Days	If less than one day
83 ? ?	? 3	? 9	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name John MacIntyre
13. Birthplace Scotland

MOTHER
14. Maiden Name Jean Stewart
15. Birthplace Scotland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 13 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 1 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

F 0866

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1944, at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1930 to 4/10 1944 and that I last saw h(im) alive on 4/10 1944.

Immediate cause of death Obstruction for Cure
Due to Arteriosclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: ? ? ?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Nash M.D.
Address B. C. H. Date signed 4/12/44

G 16147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16147 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balti General Hosp.tal
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL APR 1 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) APR 13 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

0867

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1944, at 3:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Hypertrophy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur? —

(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —

(d) Means of injury

23. Signature Chas. J. Schwab M.D. Medical Examiner.

Date signed 3/23/44

VS 151

FORMS WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16148 Registered No. 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINTED RECEIVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 Liberty Heights (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Perdue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-3-44

8. AGE: Years | Months | Days | If less than one day: hr. min.
1

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willard
13. Birthplace W. Va.

MOTHER
14. Maiden Name Kathryn Hill
15. Birthplace W. Va.

16 (a) Informant Kathryn H. Perdue
(b) Address 3911 Liberty Hgts Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14-44 (month) (day) (year)
(c) Cemetery or crematory Saint Agnes Burial Ground
Location Balto. Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) [illegible] registrar Huntington Williams M.D.

APR 13 1944
VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1944 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 19XX to 4-4 19XX, and that I last saw her alive on 4-4 19 44.

Immediate cause of death: Premature — Duration: hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos J Abbott M. D.
Address 4505 Liberty Heights Date signed 4-6-44

16149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 16149

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Park Board Road
(c) Hospital or institution: Park Liberty Sanitarium

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Hillsdale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emory Ellsworth Barber

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Jennie Hager Barber
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1862

8. AGE:

Years	Months	Days	If less than one day
82	2	24	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation Retired Builder
11. Industry or business

FATHER
12. Name Barber
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Hannah Frank
15. Birthplace Carroll Co., Md.

16 (a) Informant Helen V. Carr
(b) Address 3810 Hillsdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15-44 (month) (day) (year)
(c) Cemetery or crematory St Pauls
Location Arcadia Md.

18 (a) Funeral director Harry N. Armason
(b) Address 4204 Ridgewood Ave.

19 (a) APR 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13-1944, at 11:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to

Other Conditions Hypertrophy - dilation of Heart. Coronary Disease. Gen. Art. Sclerosis. Chronic Nephritis. Edema of Brain (Including pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 4-13-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

G 16150 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1955 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1955 W. Mulberry St.,
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ellen McGuigan Doyle.

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife James Doyle,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1881

8. AGE: Years 62 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Howard County, Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name William DuBritton,
13. Birthplace unknown

MOTHER
14. Maiden Name Mary Kane,
15. Birthplace unknown

16 (a) Informant Louis J. McGuigan,
(b) Address 1955 W. Mulberry St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. City.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

(a) Date received by registrar APR 13 1944 (b) Signature of registrar Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1944, at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1940 to April 11 1944, and that I last saw h[illegible] alive on April 11 1944.

Immediate cause of death	Duration
Angina Pectoris	
Due to Arteriosclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 4710 Liberty Heights Date signed 4/12/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 16151
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2118 Ramsay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2118 Ramsay Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Conrad Dorn

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-09-1678

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bertha Dorn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1878

8. AGE: Years	Months	Days	If less than one day
65	10	30	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Garage Manager
11. Industry or business Public Garage

FATHER
12. Name John Nicholas Dorn
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Born
15. Birthplace Baltimore, Maryland

16 (a) Informant Bertha Dorn
(b) Address 2118 Ramsay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director George P. Schaub
(b) Address 741 Frederick Avenue

19 APR 13 1944 (Date rec'd by registrar) Entering for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to April 12 1944, and that I last saw h[illegible] alive on April 12 1944.

Immediate cause of death, Coronary Occlusion — Duration
Myocarditis Chronic
Asthma
Due to
Due to
Other Conditions Pulmonary Edema
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Peters M. D.
Address 251 Walbrook Ave Date signed 4/13/44

VS 3

G 16152 Dr. Laforest

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16152

Registered No. 93E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 623 N. Spring St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 623 N. Spring St (If rural give location)

(e) Citizen of foreign country? (Yes or No) V

If yes, name country

3 (a) FULL NAME Carrie Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Charles Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1875

8. AGE: Years 68 Months 9 Days 28 If less than one day hr min

9. Birthplace Eastern Shore Md (Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Ellis Tolson

(b) Address 623 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy Wilson

(b) Address 1000 Br[illegible]

19 (a) Date rec'd by registrar APR 13 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 19 1944, to Apr 8 1944, and that I last saw h alive on 19

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Myocarditis

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert A. Laforest M. D.

Address 822 N. Broadway Date signed 4/8/44

G 16153 G 16153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4 days.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1318 Fremont Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓

If yes, name country

3 (a) FULL NAME Robert Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1941

8. AGE: Years	Months	Days	If less than one day: hr.	min.
2 yrs	7	19		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER

12. Name James W. Neal

13. Birthplace N. C.

MOTHER

14. Maiden Name Dorothy Holton

15. Birthplace Baltimore, Md.

16 (a) Informant Dorothy Holton

(b) Address 1318 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/44 (Month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elmer O. Wilson

(b) Address 1000 Brantley Ave

19 (a) 1944 (b) Received by registrar Huntington Williams M.D. Registrar

APR 13

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1944 to April 11 1944, and that I last saw him alive on April 8 1944

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. G. Maguire M. D.

Address Provident Hospital Date signed 4/13/44

16154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 16154 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore Gen.
(c) Hospital or institution: Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d.
(e) Length of stay in Baltimore (yrs., mos., or days) +21 h.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 Millington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** RICHARD SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) apr. 8. 1944

8. AGE: Years | Months | Days 2 | If less than one day 21 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry L. Scott

13. Birthplace Md.

MOTHER 14. Maiden Name Mary E. Klein

15. Birthplace Md.

16 (a) Informant Harry Scott

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL APR 13 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 APR 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH april 11 1944, at 6 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from april 8 1944 to april 11 1944, and that I last saw him alive on apr 11 1944.

Immediate cause of death

Prematurity 6m

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Partial atelectasis of lungs

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul M. Friedman M.D.

Address West Balt. Gen. Hosp. Date signed 4/13/44

VS 250

0869

G 16155 Copy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 56 E

G 16155
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — St Agnes Hospital
(b) Street address — Wilkens & Caton Aves
(c) Hospital or institution: Baltimore Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Madeira St
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Joseph Kolman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race Neth

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary Kolman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1857

8. AGE: Years 86 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Woman

11. Industry or business City El. Dept.

FATHER
12. Name Joseph Kolman
13. Birthplace Bohemia

MOTHER
14. Maiden Name Hartman
15. Birthplace Bohemia

16 (a) Informant Mary Velenarsky
(b) Address 901 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt Md

18 (a) Funeral director Frank Brockley
(b) Address 900 N Chester St

19 APR 13 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/ 1944, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19... to 1944.
and that I last saw h im alive on 4/12/ 1944.

Immediate cause of death Papiloma Lungs — Duration

Due to

Due to

Other Conditions Terminal Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation 3/17/44 / 3/23/44

Major findings of operation: Papilloma Lungs

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature. Wm. H. Muse M. D.

Address St. Agnes Hosp. Date signed 4/13/44

G 16156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G 16156 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1738 E. Chase street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Panzarella

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Paul Panzarella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1871

8. AGE: Years	Months	Days	If less than one day
72 73	10	26	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Anthony Arigo
13. Birthplace Italy

MOTHER
14. Maiden Name Marie Di Domenico
15. Birthplace Italy

16 (a) Informant Anthony Panzarella
(b) Address 1738 E. Chase st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto., Md.

18 (a) Funeral director Frank Jacchia & Son
(b) Address 900 N. Chester Street

19 (a) APR 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1944, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed 4-12-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 16157

16157

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 Greenmount Ave
(c) Hospital or institution: Southern Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Shamrock Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Hanlon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ David Hanlon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 24th 1867

8. AGE: Years	Months	Days	If less than one day
77	0	19	hr. min.

9. Birthplace Lederach Pa.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Joseph Gallagher
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Kirkwood
15. Birthplace Ireland

16 (a) Informant R. V. Murray
(b) Address 3401 Shannon Drive

17 (a) Removal (b) Date thereof 4/14/44
~~(Burial, cremation, or~~ removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ St. Anns
Location Freeland, Pa.

18 (a) Funeral director Wm Cook Inc

(b) Address 1217 St. Paul St

APR 14 1944 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13th 1944, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943, to April 13th 1944, and that I last saw h alive on April 13th 1944.

Immediate cause of death	Duration
Cerebral apoplexy	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Thomas M.D.
Address 1012 Dst Spencer Pa. Dated 4/15/44

G 16158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

Registered No. G 16158

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Exson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4+9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Exson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-13-2430

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Minnie Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27th 1873

8. AGE: Years	Months	Days	If less than one day
65	6	14	hr. min

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Electricians Helper
11. Industry or business B & O R. R.

FATHER
12. Name Michael Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Jane McGlone
15. Birthplace Ireland

16 (a) Informant Mrs Minnie Murphy
(b) Address 1703 Exson St

17 (a) Burial (b) Date thereof 4/14/44
(Burial, ~~cremation, or removal~~) (Month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Coon - MC
(b) Address 1217 E. Fort Ave

APR 14 1944 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11th 1944, at 12 M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1944 to April 11 1944, and that I last saw him alive on April 10 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Hypertension Cardiovascular Renal Disease — ?

Due to Arteriosclerosis — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M.D.
Address 626 E. Preston St Date signed 4/11/44

LeCLAIR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G 16159

G 16159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1241 W. Cross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1241 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Lee Clair (LeCLAIR)

3 (b) If veteran, name war: World War-1

3 (c) Social Security Account No. 217-05-6137

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha J. Le Clair

6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1885

8. AGE: Years 58 | Months 7 | Days 27 | If less than one day: hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Victory Homes Inc

FATHER
12. Name Albert Le Clair
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Bertha J. Le Clair
(b) Address 1241 W. Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 15 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Mrs. John W. Funkhouser
(b) Address 801 W. Fayette St.

19 (a) APR 14 1944 (date received) (year) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 11 1944 at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to April 11 1944.
and that I last saw h[illegible] alive on April 11 1944.

Immediate cause of death

Abscess of Bladder — Duration: 2 wks

Due to Staphylococcus Infection — Duration: 2 Wks

Due to

Other Conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schofield M.D.
Address 130 Compton St Date signed 4/11/44

16160

BALTIMORE CITY HEALTH DEPARTMENT X V G 16160

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County New York
(c) City or town Brooklyn, New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 952 St. Marks Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bert Gould

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Susie Gould
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day: hr.	min.
48				

9. Birthplace St. Vincent B.W.I. (Town, county, and state)
10. Usual Occupation Showman
11. Industry or business

FATHER
12. Name James Gould
13. Birthplace St. Vincent. B.W.I.

MOTHER
14. Maiden Name Emily Lightbourn
15. Birthplace St. Vincent B.W.I.

16 (a) Informant Susie Gould (wife)
(b) Address 952 St. Marks Ave Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17 - 1944 (month) (day) (year)
(c) Cemetery or crematory Cypress Hill Cemetery
Location Brooklyn.

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) Date received by local registrar APR 14 1944 (b) Filed by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1944, at 3 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1944 to April 13 1944, and that I last saw him alive on April 13 1944.

Immediate cause of death Hypertensive - renal disease — Duration

Due to

Due to

Other Conditions Terminal 4 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Hanford M. D.
Address Provident Hospital Date signed 4/13/44

G 16161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G 16161

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamlett Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3230 Elmora Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Grimm

3 (b) If veteran, name war —

3 (c) Social Security Account No. — — —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Male	White	Widowed

6 (b) Name of ~~husband~~ ~~wife~~ Elizabeth Grimm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7th 1870

8. AGE: Years	Months	Days	If less than one day
74	0	3	hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Carpenter

FATHER
12. Name Gideon Grimm
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret "
15. Birthplace "

16 (a) Informant Mrs Marie King
(b) Address 3230 Elmora Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Trinity Church
Location Towson, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St

19 (a) ~~Registrar's Signature~~ (b) Registrar

APR 14 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th 1944, at 5 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1944, to 4/12 1944 and that I last saw h~~im~~ alive on 4/12 1944.

Immediate cause of death Mitral Insufficiency — Duration

Due to

Due to

Other Conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. J. Nuesch, M. D.

Address 7101 Harford Road Date signed 4/13/44

BALTIMORE CITY HEALTH DEPARTMENT ✓ G 16162

CERTIFICATE OF DEATH

Registered No. 16162

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave
(c) Hospital or institution: Arsen Nursing Home 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 N. Calvert st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lelia B. Thomson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~ widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Wilbur S. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17th 1878

8. AGE: Years	Months	Days	If less than one day
65	7	25	hr. min.

9. Birthplace Luray Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Wm T. Birdler
13. Birthplace Va.

MOTHER
14. Maiden Name Flora C. Burnacker
15. Birthplace Va

16 (a) Informant Paul McA. Birdler
(b) Address 218 E. Lexington st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4, 14, 44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 1217 St. Paul st.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) APR 14 1944 Huntington Williams
Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th 1944 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8- 1944. to 4-12 1944.
and that I last saw h alive on 4-12-1944.

Immediate cause of death	Duration
Pneumonia - Terminal.	3 days
Due to Hemiplegia right.	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard F. Warner M. D.
Address 2604 Garrison Blvd Date signed 4-12-44.

451701 16163

BALTIMORE CITY HEALTH DEPARTMENT 6 16163 Registered No.

CERTIFICATE OF DEATH 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Brighton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Sedarc

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-86

8. AGE: Years 57 | Months 9 | Days 12 | If less than one day: hr. min.

9. Birthplace Russia Greece (Town, county, and state)
10. Usual Occupation Home
11. Industry or business —

FATHER
12. Name Hias Sedar
13. Birthplace Russia Greece

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director Williams Cook - Inc
(b) Address 129 St. Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

APR 7 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1944, at 940 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 28 1944, to Apr 9 1944, and that I last saw him alive on Apr 9 1944.

Immediate cause of death: Respiratory Failure — Duration
Due to: Uremia
Due to: Malignant arteriolo nephrosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Lorein M. D.
Address J. Hopkins Date signed 4-10

G 16164

BALTIMORE CITY HEALTH DEPARTMENT G 16164 Registered No.

CERTIFICATE OF DEATH 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 334 Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 3 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore #7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Dorchester Road (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Cora Wickliffe Berger

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	21 05 E

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
F	W	Widowed

6 (b) Name of husband ~~Chas~~ F. Berger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 29 Nov. 1870

8. AGE: Years	Months	Days	If less than one day
73	4	15	hr 14 min

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Mr. Andrew Jackson Wickliffe
FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Parthenia Elizabeth Dashiell
MOTHER 15. Birthplace Maryland

16 (a) Informant Son (John W. Berger)
(b) Address 3902 Dorchester Rd.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4, 15, 44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Williams Coop Inc
(b) Address 3 E Saratoga St Huntington Williams, Mgr

(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 April 1944 at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Feb 1944 to 13 April 1944 and that I last saw h alive on 13 April 1944.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill II M. D.
Address Union Memorial Hosp Date signed 4-17-44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16165 - 87405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D Registered No. 16165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1026 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mathilda Merriken

3 (b) If veteran, name war: N

3 (c) Social Security Account No. NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar, 8, 1870

8. AGE: Years 74 | Months 1 | Days 4 | If less than one day hr min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John D. Maier
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director William Cox, Inc
(b) Address 1417 W. Lanvale St.

19 (a) APR 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1944 at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1944 to 4/12 1944 and that I last saw h alive on 4/12 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 72 hr.

Due to A.S. CVD — ?

Due to

Other Conditions Uremia ?; Dehydration — 72 hr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Thrombosis of temporal; encephalomalacia

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M.D.
Address BCH Date signed 4/12

G 16166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 16166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5302 Catalpha Rd
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5302 Catalpha Rd. (If rural give location)
(e) Citizen of foreign country? -no- (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Jelenko Blake

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Wallis S. Blake
6 (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) April 21 1885
8. AGE: Years 58 | Months 11 | Days 23 | If less than one day: hr. 12 min.
9. Birthplace Charleston W. Va. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Gustav Jelenko
13. Birthplace Austria

MOTHER
14. Maiden Name Nannie Loeb
15. Birthplace Germany

16 (a) Informant Wallis S. Blake (husband)
(b) Address 5302 Catalpha Road.
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Apr 15-44 (month, day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore
18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (E. F. Woodall Mgr.) 100 S. Eutaw Avenue
APR 14 1944 (Date rec'd by registrar) (Huntington Williams, M.D.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13- 1944 at 2 M
21. I certify that death occurred on the date above stated; that I attended deceased from 4-1- 1944 to 4-13- 1944 and that I last saw her alive on 4-12- 1944

Immediate cause of death — Duration

Due to Acute cardiac dilatation
Due to Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wallis S. Blake
Address Med arts Bldg M. D.
Date signed

G 16167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. G 16167

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4037 Belle Av.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4037 Belle Av (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Robert James MacGregor

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie D W MacGregor

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Feb 16 1879

8. AGE: Years 65 | Months 1 | Days 28 | If less than one day: hr. 27 min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business Law

FATHER
12. Name Robt MacGregor
13. Birthplace Scotland

MOTHER
14. Maiden Name Anna Gardner
15. Birthplace Scotland

16 (a) Informant Mrs Bessie D W MacGregor (wife)
(b) Address 4037 Belleav

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 17 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (U. F. WOODEN SUC.) 108 E. NORTH AVENUE

19 (a) APR 14 1944 (Date rec'd by Registrar) (b) Huntington Mill Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1944 at 3:04 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to April 1944 and that I last saw h alive on April 13 1944.

Immediate cause of death	Duration
Arterio sclerosis	4 + yrs.
Chronic nephritis	"
Due to	
Due to	
Other Conditions Arthritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Dan Moore M. D.
Address 3105 Belair Rd Date signed 4-14-44

16168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-27

G 16168
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 N Patterson Park Ave.
(c) Hospital or institution: ********
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Homewood Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ******* years

3 (a) FULL NAME Katherine Byrnes.

3 (b) If veteran, name war ******

3 (c) Social Security Account No. ********

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph L Byrnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1895

8. AGE: Years 48 | Months 8 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Joseph Heffernan
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Harriet Kearney
15. Birthplace Baltimore Md.

16 (a) Informant Harry Heffernan (Brother)
(b) Address 2015 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** April 15 1944 (month) (day) (year)
(c) Cemetery or crematory St. Vincents Cemetery
Location Belair Rd Baltimore Md.

18 (a) Funeral director J Melville Jenkins
(b) Address 2343 Kirk Ave

19 (c) APR 14 1944 (Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1944 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-[illegible] 19[illegible] to 4-12 1944. and that I last saw [illegible] alive on 4-11 1944.

Immediate cause of death

Due to Hypertension Cardio Vascular Renal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration
17.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 4-14-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 16169
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 W Hamburg St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 W Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph L Bullock

3 (b) If veteran, name of war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Madora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-1868

8. AGE: Years	Months	Days	If less than one day
75	4	8	hr. min.

9. Birthplace Balto Md (Town, county and state)
10. Usual Occupation Fertilizer Mfg
11. Industry or business

FATHER
12. Name Joseph L
13. Birthplace Md

MOTHER
14. Maiden Name Emma M Myers
15. Birthplace Md

16 (a) Informant Madora Dwyer Bullock
(b) Address 2225 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Rd

18 (a) Funeral director Edward Tooley
(b) Address 2339 Woodland Blvd

19 (a) (Local registrar) (b) Huntington Williams, M.D.

APR 14 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1943 to April 14 1944, and that I last saw h[illegible] alive on April 13, 1944

Immediate cause of death — Duration

Acute Cardiac failure 1hr
Due to Cardio Vascular disease 4 mos
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. J. McKinstry M. D.
Address 320 Bank Blvd Date signed 4-13 1944

BARIUM RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 482 G

Registered No. 7978

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 N. Paca St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da
(e) Length of stay in Baltimore (yrs., mos., or days) over 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Paca St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Rosie Robinson
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	widowed

6 (b) Name of husband or wife James L. Robinson
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 30 1883

8. AGE: Years	Months	Days	If less than one day
60	10	14	hr ____ min

9. Birthplace Bridgeville Del (Town, county, and state)
10. Usual Occupation House work
11. Industry or business own home

FATHER 12. Name	[illegible]
13. Birthplace	Del
MOTHER 14. Maiden Name	Sallie Peck
15. Birthplace	Del

16 (a) Informant Chester Robinson
(b) Address 609 Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location Arbutus Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsa ave

19 (a) [illegible] (b) Huntington Williams, M.D.

APR 14 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13 1944, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1- 1944, to 4-13- 1944, and that I last saw her alive on 4-12-1944.

Immediate cause of death	Duration
Carcinoma uteri	April 1944
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St. Date signed 4-13-44

G 16171

G 16171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 442 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore
(If outside city or town limits, write RURAL and give town)
d Street No. 700 N. Broadway
(If rural give location)
e Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY OREM

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edwin F. Orem

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1872

8. AGE: Years 72 | Months 1 | Days 21 20 | If less than one day: hr min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Louis P. Lehr
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Steinmiller
15. Birthplace Alleghanny Pa.

16 (a) Informant Clarence G. Lehr
(b) Address 700 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) APR 14 1944 (b) Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944 at 4.30AM

21. I certify that death occurred on the date above stated, that I attended deceased from May 1943 to April 11 1944, and that I last saw h alive on April 11 1944.

Immediate cause of death: Hodgkin's disease — Duration: 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1720 Eutaw Pl Date signed 9/12/44

G 16172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48a

G 16172 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution:
Ventura Convalescent Home 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [illegible]
(c) City or town Chestertown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline W. Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Alfred K. Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1856

8. AGE: Years	Months	Days	If less than one day
87	8	4	hr min

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Walters
13 Birthplace Maryland

MOTHER
14. Maiden Name Susan Booth
15. Birthplace Virginia

16 (a) Informant Mrs. John W. Bartkowski
(b) Address 5213 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodland Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Funeral Home
(b) Address 4510 Liberty Heights Ave.

19 (a) APR 14 1944 (Date received by registrar) Huntington Williams, M.D. (registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944 at 5 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1944 to April 12 1944.
and that I last saw her alive on April 10 1944.

Immediate cause of death
Carcinoma of Larynx
Secondary Pulmonary Edema
Due to

Duration
4 mos
3 days

Due to Arteriosclerosis Cardiovascular Renal
Other Conditions Disease.

15 yr

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. F. Abbott M D
Address 4509 Liberty Hgts Ave Date signed

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6 16173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2557 W. Fairmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2557 W. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Compton I. Duval

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 705-05-3693

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Duval

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.): October 27, 1878

8. AGE: Years 65 | Months 5 | Days 16 | If less than one day: hr. min.

9. Birthplace: Roseburg, West Virginia (Town, county, and state)

10. Usual Occupation: Fireman

11. Industry or business: B & O RR

FATHER
12. Name: Maynard Duval
13. Birthplace: United States

MOTHER
14. Maiden Name: Dorothy Buzzard
15. Birthplace: Frederick, Md.

16 (a) Informant: Mrs. Compton I. Duval
(b) Address: 2557 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17, 1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Willis Amoreau
(b) Address: 1006 W. Baltimore St.

19 (a) APR 14 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1944 at 2.30A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 10 1944 to 4/13 1944, and that I last saw him alive on 4/12 1944

Immediate cause of death: Coronary Thrombosis / Cardiac Decompensation — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Samuel T. Hanson M.D.

Address 2501 W. Baltimore St. Date signed

G 16174

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16174 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1449 Andre St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore (If outside city or town limits, write RURAL and give town)
d Street No. 1449 Andre St. (If rural give location)
e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles Philip Brown

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 25, 1879

8. AGE: Years 64 | Months 8 | Days 18 | If less than one day: hr min

9. Birthplace Hamburg, Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Gotfried Sauers
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Charles Philip Brown
(b) Address 1449 Andre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 1093 W. Baltimore St.

19 (a) APR 14 1944 (Date rec'd by registrar) (b) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1944 at 4 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 31 1943 to 4/13. 1944 and that I last saw her alive on 4/12/ 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration: 1

Due to - - - -

Due to - - - --

Other Conditions Chronic aortic regurgitation of heart. — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deiter, M.D.
Address 1224 Hanover St. Date signed 4/14/1944.

G 16175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 16175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Cox St - 1.0.A
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Cox St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilbert Hedrick

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-1497

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Sarah E. Hedrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1892

8. AGE: Years	Months	Days	If less than one day: hr	min
51	7	1		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Milkman
11. Industry or business Green Spring dairy

FATHER
12. Name George E. Hedrick
13. Birthplace Md.

MOTHER
14. Maiden Name Elinor E. Hudson
15. Birthplace Md.

16 (a) Informant: Sarah E. Hedrick
(b) Address 3810 Gallo Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 15 '44
(c) Cemetery or ~~crematory~~ Poplar, Location Balto Co. Md.

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Edmondson Ave

APR 14 1944 (Date rec'd by Registrar) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944, at 7P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? (While at work)
(d) Means of injury

23. Signature Chester J. Fulvimari M.D. (Medical Examiner)
Date signed 4/12/44

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 1617 — Registrar's No. G 26136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. yrs., mos., or days 34 days
(e) Length of stay in Baltimore yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED:
a. State Md b. County
c. City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
d. Street No 846 Rennhart ST.
(If rural, give location)
e. Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Earl Bishop

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 1939

8. AGE: Years 5 | Months 9 | Days 12 | If less than one day hr min

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Jerry Bishop
13. Birthplace Md

MOTHER 14. Maiden Name Effie Smith
15. Birthplace Md

16 (a) Informant Jerry Bishop
(b) Address 846 Rhinehardt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pleasant

19 (a) [illegible] (b) [illegible]

APR 14 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1944, at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944, to April 13 1944, and that I last saw h[illegible] alive on April 13, 1944

Immediate cause of death Respiratory failure — Duration Terminal

Due to Malnutrition & Emaciation 1 mo

Due to Chronic Intestinal Obstruction 2 wks

Other Conditions Incomplete Rotation of Colon?
(Exclude pregnancy within 3 months of death)

Date of operation

Major findings of operation: Colostomy

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Wm. Earl Steele
Address Univ. Hosp. Date signed 4-13-44 M

PHYSICIAN
Underline the cause to which death should be charged statistically

G 16177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16177 Registered No. 46B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore Maryland
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Mosher Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Dunlap

3 (b) If veteran, name war —
3 (c) Social Security Account No. 243-01-5892

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ardine Dunlap.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1898

8. AGE: Years	Months	Days	If less than one day
45	9	2	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Dunlap
13. Birthplace N. C.

MOTHER
14. Maiden Name Ida Spencer
15. Birthplace N. C.

16 (a) Informant Ardine Spencer
(b) Address 1113 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/44 (month) (day) (year)
(c) Cemetery or crematory Greenlus
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Greenmount Ave

19 (a) APR 14 1944 (Date received by registrar) (b) Registrar

VR 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1944 at 6.30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Stomach.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed April 12, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G 16178 Registered No.

$3a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2008 Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE MAY STONESIFER

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Harry M. Stonesifer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/1894

8. AGE: Years 49 | Months 11 | Days 28 | If less than one day hr min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Jacob
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Yinger
15. Birthplace Germany

16 (a) Informant Mr. Harry M. Stonesifer
(b) Address 2026 Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Signature of registrar) (b) Registrar

APR 14 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 12, 1944, at 4:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1944 to April 12 1944, and that I last saw her alive on April 12 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 1 wk

Due to: Hypertension — 7

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Lachman

Address 23 N Calhoun Date signed April 17 1944

G 16179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

G 16179
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 Evesham Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Evesham Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Kolbe

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Martha L. Kolbe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1857

8. AGE: Years	Months	Days	If less than one day
86	6	8	hr. min.

9. Birthplace Baltimore County, Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Otto Kolbe
13. Birthplace Unknown.

MOTHER
14. Maiden Name Caroline Bentz
15. Birthplace Unknown.

16 (a) Informant Dora M. Meade
(b) Address 424 Evesham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 1944 (month) (day) (year)
(c) Cemetery or crematory Carroll's Chapel Cem.
Location Near - Brooklyn ville, Md

18 (a) Funeral director Durward D. Covington
(b) Address 21 W. 20th St.

19 (d) APR 14 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1943 to April 12, 1944, and that I last saw him alive on April 12, 1944.

Immediate cause of death — Duration

Chronic Myocarditis — 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Kolbe M. D.
Address 6014 York Road Date signed 4-12-44.

G 16180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 937

G 16180 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 W. Lexington St
(c) Hospital or institution: D.O.A.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Turpin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C.

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife John Marshall Turpin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1883

8. AGE. Years 64 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Hawkins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Clara Hulbert
15. Birthplace Balto. Md.

16 (a) Informant Agnes Hall
(b) Address 1218 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

APR 14 1944 (b) Registrar
(Date received by local registrar)

VS 151

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944, at 6P. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive C.V. Disease
Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski M.D.
Medical Examiner.
Date signed 4/12/44

LUBINSKI

G 16181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G 16181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1327 N. Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Worcester
(c) City or town Pocomoke City (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 Cedar St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mae Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife Rev Elmer B Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1904

8. AGE: Years	Months	Days	If less than one day
40	— 3	— 3	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Julius Ceasar
13. Birthplace Spartenburg S.C.

MOTHER
14. Maiden Name Blanche Johnson
15. Birthplace King & Queen Co Va.

16 (a) Informant Mrs Blanche Ceasar (Mother)
(b) Address 1327 N Gilmor

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Randallstown Md.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (Date rec'd by registrar) APR 14 1944 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944, at 5.45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1944, to April 12 1944, and that I last saw h-e alive on April 11 1944.

Immediate cause of death Intestinal Obstruction (post operative) adhesions
Due to "
Due to Carcinomatosis.
Due to

Other Conditions Mitral Regurgitation
Carcinomatosis Mesenteric Pelvis
(Include pregnancy within 3 months of death)

Date of operation Nov 1943
Major findings of operation: Inoperable Carcinoma of Rectum.
of autopsy: none

Duration
about 1 wk
probably 1 year

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph E Young
Address 1424 E Monument Date signed 4/13/44

G 16182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACESED: Baltimore
(a) State Md. (b) County Catonsville
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 Melrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella C Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1878

8. AGE: Years 65 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace W. Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Angus (Dec'd)
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Rebecca (Dec'd)
15. Birthplace W. Virginia

16 (a) Informant James W. Martin
(b) Address 28 Melrose Ave Caton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Camp Hill Cem.
Location Paw Paw W. Va.

18 (a) Funeral director Easton Sons
(b) Address 608 Frederick Ave, Caton

19 (a) Filed APR 14 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/44 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 19 44 to 4/13 19 44.
and that I last saw h ER alive on 4/13 19 44.

Immediate cause of death Heart Failure — Duration

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature F. C. Kaffenger-Asst. M.D.

Address St Agnes Hosp Date signed 4/13/44

G 16183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16183 ✓ Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hosp. Tal - D.O.A

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 S. Conkling St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cleveland H. Preston ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S.

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 - 1944

8. AGE: Years	Months	Days	If less than one day: hr.	min.
	5	8		

9. Birthplace Balto md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Cleveland H. Preston Jr.
13. Birthplace Barton md

MOTHER
14. Maiden Name Anna B. Yeamouth
15. Birthplace Balto Md

16 (a) Informant Anna B. Yeamouth
(b) Address 1004 S Conkling St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Donnell St

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 N Broadway

APR 14 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944, at 6 PM

21. I certify that I took charge of the remains described above, held an Inquiry + Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumococcus, Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubrano M.D. Medical Examiner.
Date signed 4/13/44

VR 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16184

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 16184

139 a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond & Monroe
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George Baltimore
(c) City or town Hyattsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4306 Ballatin
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen C Simpson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife ARTHUR SIMPSON
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1919

8. AGE: Years	Months	Days	If less than one day: hr.	min.
24	6	27	26	

9. Birthplace KENT CO. Md.
(Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name CHARLES H. CREW
13. Birthplace Md.

MOTHER
14. Maiden Name KATIE VAN DYKE
15. Birthplace Md.

16 (a) Informant JULIAN CREW.
(b) Address CHESTERTOWN MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16 1944 (month) (day) (year)
(c) Cemetery or crematory CHESTER
Location Chester town, md
18 (a) Funeral director J. Willis Wells
(b) Address Chestertown, md.

APR 14 1944 (Date received) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1944 at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1944 to 4/13 1944, and that I last saw her alive on 4/13 1944.

Immediate cause of death	Duration
Agranulocytosis	?
Secondary Anemia	?
Due to Sulfonamide Therapy	2 Months
INFLAMMATION OF Right Pelvic Cellulitis and Abscess	?
Due to Infection of Right Breast	Weeks.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Hepatomegaly, Splenomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Shortlo M. D.
Address Union Hospital Date signed 4/13/44

G 16185

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

✓ G 16185 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2767 Chesterfield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur C. Brown Jr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-05-4016

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Jennie Brake

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1911

8. AGE: Years 32 | Months 5 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Operator

11. Industry or business Gas & Electric Co.

FATHER
12. Name Arthur Brown Sr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Witzgall
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Jessie Brown
(b) Address 2767 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 15/44 (month) (day) (year)

(c) Cemetery or crematory Woodland Memorial
Location 5601 Harford Rd. P.O.

18 (a) Funeral director Fred. A. Krauss Son
(b) Address 1216 N. Charles St.

19 APR 14 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944 at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-10-44 at 8:50 P.M. 27/1
(b) Where did injury occur? Belair Rd. Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by auto

23. Signature Henry C. Hollenweber, M.D.
Medical Examiner 488 St.
Date signed April 12, 1944.

Attest: H. L. Hollenweber, by Howard J. Mahaney, M.D.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16186

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124 B

G 16186 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 835 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. John J. Dunn
3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) Aug 26 1900

8. AGE: Years	Months	Days	If less than one day
43	7	18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Sr. Bacteriologist
11. Industry or business Baltimore City Dept. of Health

FATHER
12. Name John J. Dunn
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ellen C. Callahan
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Richard J. Ellwood
(b) Address 835 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17/44 (month) (day) (year)
(c) Cemetery or crematory Most Sacred Heart Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edmund W. Corkhill & Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

APR 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1944, at 6 10 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from March 31 1944 to April 13 1944, and that I last saw h[illegible] alive on April 12 1944.

Immediate cause of death Pneumonia (Rt. lung & left lung)
Due to Uremia
Due to Cirrhosis of Liver and hemorrhagic nephritis
Other Conditions Rheumatic heart disease
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M.D.
Address St Joseph's Hospital Date signed 4-13-44

G 16187 452367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 16187 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1716 Barnes (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kermit Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-44

8. AGE: Years 0 | Months 7 wks 1 | Days 19 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Houston Byrd
13. Birthplace ?

MOTHER 14. Maiden Name Roberta Scott
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL APR 14 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 14 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1944 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1944 to April 10 1944 and that I last saw him alive on April 10 1944

Immediate cause of death respiratory failure — Duration

Due to empyema — 2 days

Due to pneumonia — 2 days

Other Conditions premature — over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M. D.
Address Johns Hopkins Hosp. Date signed 4-11-44

VS 150

10876

G 16188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16188

452381 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (English Consul) (If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 Daisy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Gottlieb
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-44

8. AGE: Years	Months	Days	If less than one day
		2	2 hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Charles Gottlieb
13. Birthplace Md.

MOTHER
14. Maiden Name Thelma Burke
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL APR 14 1944
Commissioner of Health
18 (a) Funeral director
(b) Address
19 APR 14 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944 at 11 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1944 to April 12 1944 and that I last saw h[illegible] alive on April 12 1944.

Immediate cause of death
respiratory failure — Duration: immed.
Due to prematurity — 50 hrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M. D.
Address Johns Hopkins Hosp. Date signed 4-12-44

VS 180

0875

16189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G 16189
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6195 Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Gibula

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			15 hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Walter Gibula
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or Location JOHNS HOPKINS MEDICAL SCHOOL APR 14 1944

18 (a) Funeral director
(b) Address

19 APR 14 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1944, at 3 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1944, to April 8 1944 and that I last saw h[illegible] alive on April [illegible] 1944.

Immediate cause of death ~~Pneumonia~~

Duration
15 hrs.

Due to Respiratory failure

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M. D.
Address Johns Hopkins Hosp. Date signed 4.10.44

0874

G 16190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16190 Registered No. 939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret L. Brownell

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widowed

6 (b) Name of husband or wife Alexander Brownell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — — — — — 1872

8. AGE: Years	Months	Days	If less than one day
72	—	—	— hr. — min.

9. Birthplace Natchez, Miss.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Lynch
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Ann O'Brien
15. Birthplace Balto. Md.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (b) Date thereof 4/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Kears and Son
(b) Address 805 N. Calvert St.

19 (a) (b) Huntington Williams, M.D.
Registrar

APR 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1944 at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1944 to 4/13 1944, and that I last saw h[illegible] alive on 4/13 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature William J. Bryan M. D.
Address St Agnes Hosp. Date signed 4/13/44

G 16191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

V G 16191 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319E Monument St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319E Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Branch Attabridge

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27, 183

8. AGE: Years 60 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Nottaway Co., Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Branch
13. Birthplace Va.

MOTHER 14. Maiden Name Emma Ford
15. Birthplace Va.

16 (a) Informant Thomas Attabridge
(b) Address 319E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4- (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. County Md.

18 (a) Funeral director Mrs. Cora B. Elliott
(b) Address 1129 N. Carlton St.

19 (a) Date received by registrar APR 14 1944 (b) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944 at 7.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14-1944 to 4-11-1944 and that I last saw her alive on 4-10-1944.

Immediate cause of death Congestion

Duration

Due to

Due to

Other Conditions Partial obstruction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rev. Penniman M. D.

Address 1422 E. Chase Date signed 4-13-44

G 16192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G 16192

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belona and Belvedere Aves.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write Rural and give town)
(d) Street No. 1209 N. Patterson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reinhard E Schaefer

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Elis.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Adolph Schaefer
13. Birthplace Russia

MOTHER
14. Maiden Name Elisabeth Bergal
15. Birthplace Latvia

16 (a) Informant Mrs. Anita Sobolov
(b) Address 2208 Ardin Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/44 (month) (day) (year)
(c) Cemetery or crematory Louden Pk.
Location Frederick Rd

18 (a) Funeral director L. Heemann And Son
(b) Address 32 S. Broadway

(a) Huntington Williams, M.D. (b) Date received by registrar APR 14 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8 1941, to April 12 1944, and that I last saw h[illegible] alive on Apr. 12 1944.

Immediate cause of death

Uraemia — Duration: 4 wk

Due to Chr. arteriosclerotic cardio-vascular renal dis. — Duration: 15 yrs.

Due to

Other Conditions Paralysis agitans

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Bacon M. D.

Address 510 Taylor Ave. Date signed 4/13/44

G 16193 ✓ G 16193

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1348

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Bon Secours Hosp. 41

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 E. LOMBARD ST (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Eva Sendelbach

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH. 3 - 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	1	10		

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name JOHN SENDELBACH
13. Birthplace GERMANY

MOTHER
14. Maiden Name KATHERINE MULLEIS
15. Birthplace GERMANY

16 (a) Informant MISS BERTHA SENDELBACH
(b) Address 615 E. LOMBARD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 15 - 1944 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location .....

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave.

APR 14 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1944. 8. 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8 1944. to 4/13 1944. and that I last saw her alive on 4/13 1944

Immediate cause of death	Duration
Hydro-Pyo Nephroses	
Due to Multiple Urinary Calculi	
Due to	
Other Conditions Hypertens, C-V.D.S.	

(Include pregnancy within 3 months of death)

Date of operation Cystoscopic Exam 4/10

Major findings of operation: Urinary obstruction

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond Royer M.D.
Address Bon Secours Hosp. Date signed 4/13/44

G 16194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G 16194
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Use a typewriter if possible. Spell out the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2008 Harford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2809 Goodwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Fick, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth M. Fick
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) June 16-1887

8. AGE: Years	Months	Days	If less than one day
56	9	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Roofer - owner -
11. Industry or business

FATHER
12. Name Michael Fick
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Kerr
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth Fick
(b) Address 2809 Goodwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5805 Harford Rd.

19 (a) APR 14 1944 (Date rec'd by registrar) Huntington Hall Office, Registrar

VS 180 For S.H.L. Wallenborn, by Howard J. Meredith, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12-1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 to April 12 1944, and that I last saw him alive on April 10 1944

Immediate cause of death: Coronary Thrombosis — Duration: one hr
Due to: Mental Anxiety — 4 mos
Due to: Tobacco
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. L. Jungmann, M. D.
Address 2858 Harford Rd. Date signed 4-13-44

G 16195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16195 Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4809 Laurel Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Harry Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24/41

8. AGE: Years	Months	Days	If less than one day
0	3 wks.	21	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Harry Carter
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Frederick Ave.

18 (a) Funeral director W. W. Sluiver Inc.
(b) Address 4130 Edmondson Ave.

APR 14 1944 (a) (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 14 1944, at 1454 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 13 1944, to Apr 14 1944, and that I last saw him alive on Apr 14 1944.

Immediate cause of death Respiratory failure — Duration: 2 days

Due to Capillary bronchitis

Due to Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M.D.
Address Johns Hopkins Hosp. Date signed 4-14-44

G 16196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G 16196 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount
(c) Hospital or institution: Southern Homes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Southern Homes (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion E. Wollett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 26th 1865

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	9	17		

9. Birthplace Martinsburg W. Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Home for Aged

FATHER
12. Name Harry Wollett
13. Birthplace U. Sa.

MOTHER
14. Maiden Name Mary J. Miller
15. Birthplace Unknown

16 (a) Informant Bessie Wollett
(b) Address 3306 Roseangle Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Marys - Mount Olivet
Location Balto. Md

18 (a) Funeral director Williams Sons Inc
(b) Address 1317 St. Paul St.

APR 14 1944 (a) (Date received by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13- 1944 at R M

21. I certify that death occurred on the date above stated, that I attended deceased from Mar. 5 1944 to 4/13 1944 and that I last saw h alive on 4-12 1944

Immediate cause of death

Due to Cardiac Dilatation

Due to Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
30 da
years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno Lent C. Blake M. D.
Address Med. Arts Bldg Date signed

3156 Harford Rd

G 16197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 16197 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5401 Morells Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5401 Morells Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaretta M. Kirsch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Eugene V. Kirsch
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Aug 26 - 1902

8. AGE: Years	Months	Days	If less than one day
41	7	17	hr. min.

9. Birthplace Spangler, Pa. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Cletus N. Lantzy
13. Birthplace Pa.

MOTHER
14. Maiden Name Beatrice Logan
15. Birthplace England

16 (a) Informant Mr. Eugene V. Kirsch
(b) Address 5401 Morells Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 - - 44 (month) (day) (year)
(c) Cemetery or crematory Bermudez, Pa.
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 APR 14 1944 (Date rec'd by Registrar) (b) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13- 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943 to Apr 12 1944 and that I last saw h alive on Apr 12 1944

Immediate cause of death Carcinoma of Breast — Duration 3 yrs
Due to Secondary Lungs and Stomach — 9
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. W. Thomas
Address 3156 Harford Rd Date signed 4/14/44 M. D.

VS 150

G 16198.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16198 Registered No. 476

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 3/16/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 3/16/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 3 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

12-6

3 (a) FULL NAME LAURENCE WARFIELD

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Lida ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. ___, 1888

8. AGE: Years	Months	Days	If less than one day
56	1	—	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Edna F. Lockwood Owner of Sallie Bramble

FATHER
12. Name Robert Warfield
13. Birthplace ?

MOTHER
14. Maiden Name Sarah ?
15. Birthplace ?

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 18 1944 (month) (day) (year)
(c) Cemetery or crematory Beckwith
Location Camby, Dor. Co. Md

18 (a) Funeral director H.M. St Clair & Son
(b) Address Cambridge, Dor. Co. Md

19 (a) Date received by Local Registrar APR 14 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH April 14, 1944 at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16, 1944 to Apr. 14, 1944 and that I last saw him alive on Apr. 14, 1944

Immediate cause of death Terminal bronchial pneumonia of the left upper lobe — Duration: Unk.

Due to Metastatic squamous cell carcinoma involving the tracheal bronchial lymph nodes, anterior mediastinum, the entire thoracic cavity including destruction of the left fifth, fourth ribs & right first rib, third rib & the left diaphragm.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Schuerman M. D.
Address Baltimore, Md. Date signed 4/14/44

MS-61732

G 16199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16199
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Nottingham, (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Estle Everett Colvard
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married) widowed, or divorced.
Male	White	

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-27, 1895

8. AGE: Years	Months	Days	If less than one day hr.	min.
48	10	17		

9. Birthplace No. Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business Triumph Explosives

FATHER
12. Name Jesse R. Colvard
13. Birthplace No. Carolina

MOTHER
14. Maiden Name Nan Sheets
15. Birthplace No. Carolina

16 (a) Informant Mrs. Carl Hines, Jr.
(b) Address E. High St., Elkton, Md.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Apr. 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Elkton Md
Location
18 (a) Funeral director H. W. Pippin & Son
(b) Address Elkton Md.
19 (a) APR 14 1944 Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1944, at 5:59 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1944, to 4-14 1944, and that I last saw him alive on 4-14 1944.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Malignant Hypertension	?
Due to	
Other Conditions Chronic Nephritis.	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George W. Mungavin Jr. M. D.
Address 332 E. University Pkwy. Date signed 4/14/44

16200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132a

C 16200 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 N. Central Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1905

8. AGE: Years 38 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Pittsburg, Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Pryor
13. Birthplace Pa.

MOTHER
14. Maiden Name ?
15. Birthplace Pa.

16 (a) Informant William Wilson
(b) Address 1011 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. C. County Md

18 (a) Funeral director Joseph B. Locke
(b) Address 1384 N. Central Ave

19 APR 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1944 at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1944 to 4/13 1944 and that I last saw h[illegible] alive on 4/13 1944.

Immediate cause of death Lobar Pneumonia — Duration 3 days

Due to Influenza & Coalitis

Due to Exposure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas R. Blake M.D.
Address 1327 N. Central Ave Date signed 4/14

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16201 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Elgin Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Elgin Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Susie B. Flack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1861

8. AGE: Years	Months	Days	If less than one day
82	5	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James W. Flack
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Baker
15. Birthplace Md.

16 (a) Informant James W. Flack, Jr.
(b) Address 2931 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)
(c) Cemetery Greenmount
Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

APR 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1944 at 4 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1942, to 4/12 1944, and that I last saw h-- alive on 3/24 1944.

Immediate cause of death Coronary Occlusion — Duration Sudden

Due to Coronary arteriosclerosis — ?

Due to Arteriosclerosis — ?

Other Conditions Myocardial degeneration — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Wesley Edel M. D.
Address 3403 Garrison Blvd. Date signed

J Wesley Edel

G 16202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 16202 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days) 15 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 Pittman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Minter #1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/15/44

8. AGE: Years	Months	Days	If less than one day
			hr 15 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stafford Bern Minter

13. Birthplace

MOTHER 14. Maiden Name Jane Moore

15. Birthplace Brooklyn, N.Y

16 (a) Informant Mrs. J. Minter

(b) Address 430 pittman st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 1944 (month) (day) (year)

(c) Cemetery or crematory Woodland Park

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 Eutaw Pl. Baltimore, Md.

19 (a) (b) Registrar

Registered by

APR 13 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 1944, at 2 20 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1944, to 4/15 1944, and that I last saw him alive on 4/15 1944.

Immediate cause of death: Premature

Due to: Hydramnios

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. R. Inglis M. D.

Address Mercy Hosp. Date signed 4/15/44

G 16203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16203 Registered No. 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Min
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 Pittman Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Minter #2

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/15/44

8. AGE: Years | Months | Days | If less than one day: hr. 5 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Shepard Bern Minter
13. Birthplace

MOTHER
14. Maiden Name Jane Moore.
15. Birthplace Brooklyn, N.Y.

16 (a) Informant Mrs Jane Minter
(b) Address 430 Pittman Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 15, 1944 (Month) (day) (year)
(c) Cemetery or crematory Maryland Cem
Location Balto Co Md.

18 (a) Funeral director Williams Cook Co
(b) Address 1217 St. Paul St.

19 (a) APR 15 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 1944 at 2 15/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1944 to 4/15 1944 and that I last saw h[illegible] alive on 4/15 1944.

Immediate cause of death Premature

Due to Hydramnios

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. Bigler M. D.
Address Mercy Hosp. Date signed 4/15/44

G 16204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 16204 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Longwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ZILLAH P. GUMMER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Edward J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1862

8. AGE: Years	Months	Days	If less than one day hr	min.
81	8	23		

9. Birthplace Brunswick, Maine (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jos. Henry Morse
13. Birthplace Brunswick, Maine

MOTHER
14. Maiden Name Lucy Ellen Purington
15. Birthplace Topsham, Maine

16 (a) Informant Mrs. F. C. Gummer
(b) Address 1925 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(Date received by Registrar) APR 15 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1944, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1944, to April 13, 1944, and that I last saw h[illegible] alive on April 13 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 24 hrs

Due to Arterial Sclerosis.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? — (Specify type of place)
(e) Means of injury

23. Signature Herbert E. Jopp, M.D.
Address 3048 N. Howard Ave Date signed 4/15/44

G 16205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16205 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Amelia Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Grace V. Dreming

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Clifton Dreming
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1873

8. AGE: Years 71 | Months 1 | Days 25 | If less than one day hr min

9. Birthplace Penn. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name Edwin C. Eichelberger
13. Birthplace York Co. Pa.

MOTHER 14. Maiden Name Susan Stuckman
15. Birthplace York Co., Pa.

16 (a) Informant H. Clifton Dreming
(b) Address 616 Amelia Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Taylor Ave., Parkville

18 (a) Funeral director Mrs. J. Dykes & Son
(b) Address Ballod, Md.

19 APR 15 1944 Huntington Williams, M.D.
(Date received) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944 at 11:38 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1944 to April 14 1944 and that I last saw h(e)r alive on April 14 1944.

Immediate cause of death — Duration
Cerebral hemorrhage
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Herman Williams M. D.
Address Md. Gen. Hosp. Date signed 4-14-44

VS 150

C 16206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

C 16206 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 Parkin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 Parkin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Anna Bereburg.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife late John N.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 9th 1865

8. AGE: Years	Months	Days	If less than one day
78	7	5	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation house work.
11. Industry or business at home

FATHER
12. Name Edward Cowan
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Cleary
15. Birthplace Ireland

16 (a) Informant Mr. George Bereburg
(b) Address 34 Parkin St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral Cem
Location 4300 old Frederick Road

18 (a) Funeral director John J Cowan & Son
(b) Address 903-3 Hollins Street

19 APR 15 1944 Registered by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1944 at 7.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to April 14 1944 and that I last saw h alive on April 8 19 44.

Immediate cause of death
Carcinoma of Sigmoid Flexure of Colon — Duration 1 yr

Due to

Due to

Other Conditions Arteriosclerotic Cardiac Disease — 1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester J. Swanke M. D.
Address 5217 Falmouth Rd Date signed 4/17/44

G 16207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16207 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 a.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 S. Bouldin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna M. Bayer

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 30 1894

8. AGE: Years 49 | Months 4 | Days 14 | If less than one day 13 hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business AT HOME

FATHER
12. Name GREGOR BAYER
13. Birthplace GERMANY

MOTHER
14. Maiden Name SABINA RLINDL
15. Birthplace GERMANY

16 (a) Informant JACOB J. BAYER (BROTHER)
(b) Address 330 S. BOULDIN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 15/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (d) APR 15 1944 (Date rec'd by reg.) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1944, at 1:45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchio-pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D. (Medical Examiner)
Date signed April 14, 1944

VS 151

Please write plainly. Use ink. Every item of information should be carefully supplied if the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16208

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-85780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16208
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos- 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Gaff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 18- 1874

8. AGE: Years	Months	Days	If less than one day
69	6	27 26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William J. Gaff (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Judge (D)
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 17/44 (month) (day) (year)
(c) Cemetery or crematory Back Bay
Location

18 (a) Funeral director Geo M. Fonis & Son
(b) Address 841 N. Wolfe St

19 APR 15 1944 (b) Huntington Williams, M.D. Registrar
(Certificate received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 14 1944 at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1944 to April 14 1944.
and that I last saw h alive on 19

Immediate cause of death: Arteriosclerotic C.V.D. — Duration: ??
Due to: Arteriosclerosis — Duration: ??
Due to:
Other Conditions: Jaundice & Lower Extremities
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Pierpont M. D.
Address Balto City Hosp Date signed April 17 1944

G 16209

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 16209
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Walnut Ave
(c) Hospital or institution: 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Glenwerton Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis M. Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
M	W	Married

6 (b) Name of husband or wife Mary Ann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/1860

8. AGE: Years	Months	Days	If less than one day
83	4	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Builder & Real Estate
11. Industry or business

FATHER 12. Name	Miller
FATHER 13. Birthplace	Virginia
MOTHER 14. Maiden Name	Margaret Donaldson
MOTHER 15. Birthplace	Virginia

16 (a) Informant Mrs. Agnes Miller
(b) Address 4400 Glenwerton Rd

17 (a) Cremation (b) Date thereof 4-15-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Harry G. Wilson
(b) Address 4011 Edmondson Ave

19 (a) APR 15 1944 (b) Huntington Williamsport, Md.
(Date rec'd by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1944, at 7:50 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCauley M.D.
Medical Examiner.
Date signed 4/13/44

...correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16210 — BALTIMORE CITY HEALTH DEPARTMENT — G 16210

CERTIFICATE OF DEATH 479

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully verified. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Caulbourn
(c) Hospital or institution: Franklin Sq. Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 W. Baath. St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Elizabeth Reippel

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Philip A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3 1873

8. AGE: Years	Months	Days	If less than one day
70?	10	11	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Wife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Philip A. Reippel
(b) Address 123 Doris Ave. Brooklyn Park Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 18 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem Md
Location

18 (a) Funeral director Pott & B. M Walters
(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by registrar) APR 15 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1944 at 6.05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1944 to 4/14 1944 and that I last saw h 2 alive on 4/13 1944.

Immediate cause of death Pneumonia
Due to effusion - hemo of
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Franklin Sq. Hosp. Date signed 4/14/44

G 16211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16211 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 341 [redacted] S. Woodyear St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs 341 [redacted] S Woodyear St

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary E. Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John A Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9 1871

8. AGE: Years 72 | Months 7 | Days 4 | If less than one day: hr min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Bell

13. Birthplace md

MOTHER 14. Maiden Name Ann N. Valiant

15. Birthplace md

16 (a) Informant John A Ruth

(b) Address 3042 Abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 17 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park City

Location

18 (a) Funeral director Rolf & B M Walter

(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by registrar) APR 15 1944 (b) Hunting Town Williamsport

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1944 at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 43 to 4/13 19 44 and that I last saw h e alive on 4/13 19 44

Immediate cause of death Arterio sclerotic Cardio Vascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Benjamin Miller M.D.

2030 Wilkens Ave

Date signed 4/13/44

G 16212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G 16212 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3209 Woodland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Woodland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rena May Maggio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Samuel Maggio 6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Feb. 10 - 1896

8. AGE: Years 48 | Months 2 | Days 2 | If less than one day 2 hr. min.

9. Birthplace Brunswick Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business –

FATHER
12. Name Hilery Kidwell
13. Birthplace Brunswick Md

MOTHER
14. Maiden Name Mary Agnes Phillips
15. Birthplace Brunswick Md.

16 (a) Informant Dorothy Schwartz
(b) Address 33 52 Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Loring Byrne.
(b) Address 5005 Park Heights Ave.

19 APR 15 1944 Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 12 - 1944 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 - 12 - 1942 to 4 - 12 - 1944 and that I last saw her alive on 4 - 12 - 1944

Immediate cause of death Apoplexy — Duration Few hours
Due to Hypertension — Duration Years
Due to Cardio - renal disease — Duration Years
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. B. Lybert M. D.
Address 1302 Hanford Rd Date signed 4-14-44

G 16213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16213

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 15
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 78 Liberty (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Joseph Stem

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace

MOTHER 14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Mrs Burn Miller
(b) Address 1208 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Bithel
Location Jamesonuk, Md.

18 (a) Funeral director P B Bankard & Son
(b) Address Westminster, Md.

APR 17 1944

(a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1944 to April 15 1944. and that I last saw her alive on April 14 1944.

Immediate cause of death Heart failure — Duration 2

Due to arteriosclerosis — Duration .

Due to arteriosclerotic Heart Disease — Duration 2

Other Conditions — Duration .

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein, M. D.

Address 878 W 36th St Date signed 4/15/1944

G 16214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 16214
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Gallaway St
(c) Hospital or institution: Gallaway St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city limits, write RURAL and give town)
(d) Street address 607 Gallaway St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Johnson

6 (c) If alive, give age years

7. Birth date of deceased (Month) Feb 4 1913

8. AGE: Years	Months	Days	If less than one day
029	7	9	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Dock Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Britton
15. Birthplace Va

16 (a) Informant Sarah Britton
(b) Address 607 Gallaway St

17 (a) Burial (b) Date thereof 4/15/44
(Burial, cremation, or removal) (Month) (day) (Year)

(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. G. Kellam
(b) Address 1383 Pressbyman

19 APR 15 1944 (b) Huntington Williamsburg, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/44 19 .0 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/07/44 to 4/12/44 and that I last saw deceased alive on 4/12/44

Immediate cause of death
(a) Acute Pulmonary Edema
Due to
(b) Cerebral Tumor
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter Salm M. D.
Address [illegible] Date signed 4/14/44

16215 W52306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G 16215
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Glenarm (If outside city or town limits, write RURAL and give town)
(d) Street No. Penn. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jerry Goettner (Jerry Lee Goettner)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-44

8. AGE: Years | Months: 1 | Days: 29 | If less than one day: hr min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Christian Goettner
13. Birthplace: Md

MOTHER 14. Maiden Name: Pauline Burdette
15. Birthplace: Md

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore, Maryland

18 (a) Funeral director: Sasaki Funeral Home
(b) Address: 7401 Belair Road

APR 15 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 14 1944, at 205A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 9 1944, to Apr 14 1944, and that I last saw him alive on Apr 14 1944.

Immediate cause of death: heart failure — Duration: 6 hrs.

Due to: pneumonia — Duration: 6 days

Due to: atelectasis — Duration: 1 day

Other Conditions: Colostomy, Anal atresia, Recto-urethral fistula — Duration: over

(Operation and pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson, M. D.
Address Johns Hopkins Hosp. Date signed 4-14-44

449783

C 16216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

Registered No. C 16216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 1031 Madison Ave (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Mary Young

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-2-04

8. AGE: Years	Months	Days	If less than one day
39	6	9	hr ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name William Weaver

13. Birthplace Va

MOTHER 14. Maiden Name Mamie Vinny

15. Birthplace Va

16 (a) Informant Record.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)

(c) Cemetery or crematory Mulberry

Location Richmond Co. Va.

18 (a) Funeral director Elroy Wilson

(b) Address 1000 Bland Lee Ave Huntington Williamsburg, Va

19 (a) [illegible] (b) [illegible]

APR 15 1944

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1944 at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1944 to April 11 1944 and that I last saw h[illegible] alive on April 11 1944

Immediate cause of death: anemia

Due to chronic hemorrhagic nephritis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature John R. Bunnington JHH

Address ..... Date signed 4/13

VS 150

G 16217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 16217
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2928 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stephen Gaisbauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1890

8. AGE: Years	Months	Days	If less than one day
53	2	29	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business Carpenter

FATHER
12. Name Franz Gaisbauer
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Panli
15. Birthplace Germany

16 (a) Informant Theresa Gaisbauer
(b) Address 2928 E Baltimore St

17 (a) Burial (cremation, or removal) (b) Date thereof 4/20/44 (month, day, year)
(c) Cemetery or crematory Holy Redeemer
Location Holabird Ave

18 (a) Funeral director John C Moran
(b) Address 3600 E Baltimore St

19 (a) APR 15 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1944, to Apr 13 1944, and that I last saw him alive on Apr 13 1944

Immediate cause of death: Coma • Insufficiency — Duration

Due to

Due to Stab Wound

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed

16218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182a

G 16218

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore Maryland

(c) Hospital or institution Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6209 Blackburn Lane (If rural give location)

Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Ann Gebhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feby 8, 1944

8. AGE: Years	Months	Days	If less than one day
	2	6	hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Robert Gebhardt

13. Birthplace Ohio

MOTHER

14. Maiden Name Margaret Kimmell

15. Birthplace Md

16 (a) Informant Robert Gebhardt

(b) Address 209 Blackburn Rd

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/15/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location

18 (a) Funeral director John C. Mitchell & Sons

(b) Address 19 or Eutaw Pl.

APR 15 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

5:45

20. DATE OF DEATH April 14 1944, at P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation.

Due to Bedclothes.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5:45? at April 14 1944 M.

(b) Where did injury occur? 6209 Blackburn Lane.

(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.

(d) Means of injury Smothering in crib corner

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.

Date signed April 15, 1944.

VS 151

G 26219 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G 26219 1 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution: US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 8 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MELTON HATFIELD

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Veovie Robinson
6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) March 29, 1901

8. AGE: Years	Months	Days	If less than one day
43	0	16	hr. min.

9. Birthplace Marion County, Tenn. (Town, county, and state)
10. Usual Occupation Electrician-Beth.Fairfield
11. Industry or business

FATHER
12. Name John Hatfield
13. Birthplace Watson County, Tenn.

MOTHER
14. Maiden Name Nannie Simms
15. Birthplace Watson County, Tenn.

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-44 (month) (day) (year)
(c) Cemetery or crematory Location Whitewell Tenn

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Road

APR 16 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1944, at 6:05 a.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 14, 1944 to April 15, 1944, and that I last saw him alive on April 15, 1944.

Immediate cause of death: Congestive Failure, heart disease, type undetermined — Duration: 3 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: No

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify one) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address US Marine Hospital, Baltimore, Md. Date signed

G 16220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 16220 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2014 Druid Hill Ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) All years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Dyson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Daniel Dyson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Leonardtown Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Smith
13. Birthplace St Mary's Co.

MOTHER
14. Maiden Name Mary E Smith
15. Birthplace St Mary's Co.

16 (a) Informant James T Dyson
(b) Address 1318 Etchelwood

17 (a) Burial (b) Date thereof April 17-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md
18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) Date received by registrar (b) Registrar

APR 16 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19XX, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 19XX to April 13 19XX, and that I last saw her alive on April 12 19XX.

Immediate cause of death: Cardio Vascular Disease — Duration: 1 yr.
Due to Cerebral Hemorrhage — 3 days.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E William Fey M. D.
Address 608 Park Ave Date signed 4/15/XX

G 16221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

G 16221 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2926 Glenmore

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2926 Glenmore Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Cronin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary C. Cronin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-29-1860

8. AGE: Years	Months	Days	If less than one day
84	-	14	hr. min.

9. Birthplace Gloucester - Mass. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name Michael Cronin

13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine Tracy

15. Birthplace Ireland

16 (a) Informant Mrs George J. Cole

(b) Address 2926 Glenmore ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-17-44 (month) (day) (year)

(c) Cemetery or crematory Holy Red.

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford rd.

(c) Filed Herbert Huntington Williams, M.D. Registrar

APR 16 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1944, at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1944 to April 13, 44 and that I last saw him alive on April 10 44.

Immediate cause of death: Carcinoma of Prostate gland — Duration: 3 Mos.

Due to:

Due to:

Other Conditions Atteriosclerosis — Duration: 5 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Louis Fitzgerald M.D.

Address 623 E North Ave Date signed 4-14-44

2305 Mayfield

G 16222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G 16222 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 Woodstock Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Woodstock Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Elizabeth Buedel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frederick Buedel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-1864

8. AGE: Years	Months	Days	If less than one day hr.	min
80	1	26		

9. Birthplace Germany (Town, county and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Fuchs
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Hartfelter
(b) Address 3402 Woodstock Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leopard J Reuck
(b) Address 5305 Harford Rd.

(Signature or address of local registrar) (b) Registrar

APR 16 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13- 19 44 at 9:53 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 5, 1944, to April 13, 1944 and that I last saw her alive on April 13, 1944.

Immediate cause of death
Congastive Heart Failure — Duration: 1 day

Due to Arteriosclerosis — Duration: Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature (Philibert Artigiani) M. D.

Address 2942 E. Fayette St. Date signed 4/15/44

G 16223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 B

✓ G 16223 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ months

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2445 Shirley Ave. Balto 15. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Mollie Greenbaum

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife Morris Greenbaum

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day hr	min.
70				

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Louis Sherman

13. Birthplace Poland

MOTHER 14. Maiden Name Unknown

15. Birthplace Poland

16 (a) Informant Mr. Morris Greenbaum

(b) Address 2445 Shirley Ave. Balto 15.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-44 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Rd.

Location N.W.M.D.R. Osgo

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 Eutaw Pl. Balto. Huntington Williams, Mgr

19 (a) Date received APR 16 1944 (by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to April 14 1944, and that I last saw her alive on April 13 1944.

Immediate cause of death Metastases to brain — Duration 6 months

Due to Carcinoma left orbit. — 7 years

Due to

Other Conditions Diabetes.

(Include pregnancy within 3 months of death)

Date of operation Feb. 2, 1944.

Major findings of operation: Curettage of orbit revealed carcinoma.

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Ellsworth Cook Jr. M. D.

Address Mercy Hospital Date signed 4-18-44

VS 150

G 16224 | BALTIMORE CITY HEALTH DEPARTMENT ✓ G 16224

CERTIFICATE OF DEATH 46F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Caldwell
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Harlem Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Helen Hoff

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Albert F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/22/1877

8. AGE: Years	Months	Days	If less than one day
46	7	22	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Mendel Agranowitz
13. Birthplace Russia

MOTHER
14. Maiden Name Rosah —
15. Birthplace Russia

16 (a) Informant Albert F.
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-44 (month) (day) (year)
(c) Cemetery or crematory Werlman Circle
Location Hebrew Mt Carmel

18 (a) Funeral director Geo. Lewis Inc
(b) Address 1439 E. Balto St

19 (a) Date received APR 16 1944 (b) Registrar Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1944 at 4:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1944 to 4/17 1944 and that I last saw h. alive on 4/17 1944.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. H. Smith M. D.
Address 21 E. Sq. Md. Date signed 4/17/44

G 16225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 16225 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Warwick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eli Rubinstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation

11. Industry or business Insurance Agent

FATHER
12. Name Myer David Rubinstein
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Schneiderman
15. Birthplace Russia

16 (a) Informant Abraham Rubinstein
(b) Address 1613 Warwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North ave

19 (a) (b)

Filed by registrar April 16 1944 Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944 at 7.46 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1944 to April 15 1944 and that I last saw h[illegible] alive on April 15 1944

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertensive cardio vascular disease

Due to

Other Conditions decompensation with pulmonary edema on admission to hospital
(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Sinai Hospital Date signed 4/15/44

G 16226

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G 16226
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked and answered. Physicians: please write the causes of death clearly and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 Oakland av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 93

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Oakland ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sarah R. Roberts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Widow

6 (b) Name of husband or wife John H. Roberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 1850

8. AGE: Years	Months	Days	If less than one day
93	6	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Daniel Whitney
13. Birthplace

MOTHER 14. Maiden Name (Georgiana) Parker
15. Birthplace Baltimore

16 (a) Informant Mrs Mary Walker
(b) Address 529 Oakland ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson ave

18 (a) Funeral director Henry Lutz
(b) Address 1203 N. Broadway

APR 16 1944 (b) Registrar
(Date received by Registrar)

Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1944 to 4/14/1944, and that I last saw h & A alive on 4/14/ 1944

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to	
Due to	
Other Conditions Bronchio-Pneumonia	4 Dys

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature John A. Hanson M.D.
Address 11 E. Chase St Date signed 4/16/44

G 16227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16227 Registered No.

12 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 E. Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Ehrman

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Dorcas S. Ehrman (Nee Tydings) 6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1894

8. AGE: Years	Months	Days	If less than one day
49	3	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Shipfitter U.S. Coast
11. Industry or business Guard Depot, Curtis Bay, Md.

FATHER
12. Name Frederick Ehrman
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Huff
15. Birthplace Baltimore, Md.

16 (a) Informant Dorcas S. Ehrman (Wife)
(b) Address 1232 E. Fort Ave. (30)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18, 1944 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location B. & O. Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 400 S Charles St., Balto 30, Md.

APR 16 1944

(a) (Local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1944, at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5-1944 to 3-24-1944 and that I last saw him alive on 3-24-1944.

Immediate cause of death

Asphyxia

Due to Th. pulmonum (lungs)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Weinberger M. D.

Address 1024 E. Fort Ave Date signed 4-17-44

G 16228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927 D

G 16228 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4311 Arabia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Arabia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY ALBERT WEAVER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Ruth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1873

8. AGE: Years	Months	Days	If less than one day
71	0	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation -- Retired Lawyer
11. Industry or business Self

FATHER 12. Name Frederick Weaver
13. Birthplace Germany

MOTHER 14. Maiden Name Sophia P. Brown
15. Birthplace Germany

16 (a) Informant Mrs. M. R. Weaver
(b) Address 4311 Arabia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem. Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 16 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 13, 1944, at 11:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from March 8 1944, to April 13 1944, and that I last saw him alive on April 13 1944.

Immediate cause of death Chronic myocarditis — Duration 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. K. Cody and M. D.
Address 5706 Harford Rd Date signed 4-15-44

G 16229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16229 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Berkshire Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Shaeffer (Anna Elizabeth Shaeffer)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Harry S. Shaeffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1877

8. AGE: Years	Months	Days	If less than one day
66	10	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert Mielke
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Vohne
15. Birthplace Germany

16 (a) Informant Mrs. George Kinlein
(b) Address 1316 E. 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Carroll Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 16 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1944 to 4/14 1944 and that I last saw her alive on 4/14 1944.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Coronary thrombosis	22 days
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond Royer M. D.
Address Bon Secours Hosp. Date signed 4/14/44

G 16230

G 16230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5310 York Rd.
(c) ~~Hospital or institution~~
Del Par Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 York Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME LOUISE PRIDHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William H. Pridham
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1864

8. AGE: Years	Months	Days	If less than one day
79	8	1	hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Edward Pridham
(b) Address Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received APR 16 1944 Huntington Williams M.D. Registrar
(b) Registered .....

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10- 1944 to 4-15- 1944 and that I last saw h[illegible] alive on 4-15- 1944

Immediate cause of death Hypertensive cardio-vascular disease — Duration 7 / 1

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operations: .....

.....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature Anthony F Lazzaro
Address 5210 York Rd Date signed 4/15/44

G 16231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 16231 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Eutaw
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL, and give town)
(d) Street No. 127 Newberry Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Kathleen Paschall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1903

8. AGE: Years 40 Months 7 Days 4 If less than one day hr min

9. Birthplace (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business

FATHER
12. Name James Paschall.
13. Birthplace North Carolina

MOTHER
14. Maiden Name Agnes Paschall
15. Birthplace North Carolina

16 (a) Informant Mrs Edna Moore
(b) Address 127 Newberry Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 18, 1944 (month, day, year)
(c) Cemetery or crematory New Hope Cem.
Location Drewry Warney Co N. Carolina

18 (a) Funeral director Easton Bone
(b) Address Ellicott City Md

19 APR 17 1944 (Must not be filled in) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 1944 at 4:55 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 4/15 1944 to 4/15 1944 and that I last saw h[illegible] alive on 4/15 1944

Immediate cause of death	Duration
Cerebral hemorrhage	?
Due to Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence (month, day, year) (hour) A.M. P.M.
(c) Where did injury occur? (City or town) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

PHYSICIAN

Underline the name to which death should be charged (Last name first)

23. Signature [illegible] M.D.
Address [illegible] Date signed 4/15/44

VS 150

Grey Room
16232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

G 16232
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2 USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S. Chapel St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alverta Carr
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-10-1929
8. AGE: Years 14 | Months 6 | Days 4 | If less than one day: hr. min
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Alexander Carr
13. Birthplace
MOTHER 14. Maiden Name Elizabeath Rockel
15. Birthplace
16 (a) Informant JOHNS HOPKINS records
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location
18 (a) Funeral director Lilly & Foster
(b) Address 1508 W. Mt. St.
APR 17 1944 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 15 1944 at 10:05 P.M
21. I certify that death occurred on the date above stated, that I attended deceased from Apr 15 1944 to Apr 15 1944 and that I last saw h[illegible] alive on Apr 15 1944

	Duration
Immediate cause of death: Respiratory failure	
Due to: edema of glottis,	
Due to: bull neck diphtheria	
Other Conditions: terminating strep infection	

Date of operation
Major findings of operation:
of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John R. Bermingham
Address JHH Date signed 4/15/46

V8 150

G 16233

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 16233
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 S.LINWOOD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days 50 YRS.

2. USUAL RESIDENCE OF DECEASED
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 S.LINWOOD AVE.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME JULIA SCHIMINSKY.
3 (b) If veteran, name war NO
3 (c) Social Security Account No. NONE
4. Sex FEMALE
5. Color or race WHITE
6 (a) Single, married, widowed, or divorced WIDOW
6 (b) Name of husband or wife FELIX SCHIMINSKY
6 (c) If alive, give age
7. Birth date of deceased mo., day, yr Feb. 16, ~~1875~~ 1878
8. AGE: Years ~~69~~ 66 | Months 1 | Days 28 | If less than one day hr min
9. Birthplace AUSTRIA (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name GEORGE MAZAN
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace AUSTRIA

16 (a) Informant MARY HERRMANN (DAUGHTER)
(b) Address 521 S.LINWOOD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR.17/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S.WOLFE ST.

APR 17 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APR.14 1944 at 12/37 AM.

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 16 1944 to April 14 1944, and that I last saw h alive on April 12 1944

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension Cardio Vascular Disease

Due to

Other Conditions

Include pregnancy within 3 months of death

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature Andrew Tankovich

Address 2529 Eutaw Pl Date signed 4/15-44

(over)

G 16234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G 16234 Registered No.

AB-86775

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mos.- 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward McDermott
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr

8. AGE: Years 65 ? | Months ? | Days ? | If less than one day hr min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace ✓

MOTHER 14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/44
(c) Cemetery or crematory Mt. Calvary Cathedral
Location Balto. Md.

18 (a) Funeral director William Cox Inc
(b) Address 1 W. Saratoga St

APR 7 1944
(Date rec'd by registrar)

Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944, at 11.45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-3 1944 to 4-14 1944, and that I last saw him alive on 4-14 1944

Immediate cause of death: Carcinoma of Esophagus

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Duration: ?

Date of operation 3-8-44

Major findings of operation: Bartholomy

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald Birkett
Address Balto City Hosp Date signed 4-14-44

G 16235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16235 Registered No.

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1039 St. Paul Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1039 St. Paul Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle D. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William F. Mitchell

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) **** 791

8. AGE: Years 53 | Months | Days 1 | If less than one day: hr. | min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Real Estate Broker

11. Industry or business ---

FATHER
12. Name Frederick W. Damast
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna C. Rebstock
15. Birthplace Maryland

16 (a) Informant Mrs. Emory Hartles
(b) Address 412 Hawthorn Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) 4/17/44 (Date rec'd by registrar) (b) Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1944 at 12:05 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner
Date signed April 15, 1944.

G 16236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16236 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 Cathedral St.
(c) Hospital or institution:

10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Ensor St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Carmelo Ecolano.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of ~~husband~~ wife Rose Ecolano
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 15 1893

8. AGE: Years	Months	Days	If less than one day
50	8	29	hr. min

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Lunch room
11. Industry or business

FATHER
12. Name Dominic Ecolano
13. Birthplace Italy

MOTHER
14. Maiden Name Nellie Sparta
15. Birthplace Italy

16 (a) Informant Rose Ecolano (Wife)
(b) Address 1023 Ensor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18/44 (month) (day) (year)
(c) Cemetery or ~~Church~~ Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 APR 17 1944 Huntington Williams M.D.
(Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14-1944 at 8P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 4-14-1944 to 4-14-1944, and that I last saw h~~im~~ alive on 4-14-1944.

Immediate cause of death Coronary occlusion — Duration 2 hrs.
Due to Hypertension — 2 yrs.
Due to Arteriosclerosis — 4 yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. J. Imaret M. D.
Address Medical arts Bldg. Date signed

G 16237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G 16237
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hours
(e) Length of stay in Baltimore (yrs., mos., or days) just came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Millersville P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Elvaton Rd near Glen Burnie
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James J Shirley.
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-05-2303

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Anna M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1889

8. AGE: Years	Months	Days	If less than one day
54	8	2	hr. min.

9. Birthplace Maryland.
(Town, county and state)
10. Usual Occupation Gate Guard.
11. Industry or business Gibson Island

FATHER 12. Name	John Shirley.
FATHER 13. Birthplace	Maryland
MOTHER 14. Maiden Name	Josephine Barley.
MOTHER 15. Birthplace	Bohemia

16 (a) Informant Anna M Shirley
(b) Address Millersville, Md.
17 (a) Burial (b) Date thereof 4/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.
18 (a) Funeral director William M. Mauck.
(b) Address 715 Light St.
19 (a) (b) Huntington Williams, Md.
(Date rec'd by registrar)
APR 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944 at 1:10 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1944 to April 14 1944 and that I last saw h[illegible] alive on April 14 1944.

Immediate cause of death Cardial failure.
Due to Arteriosclerotic Cardio-Vasc. Disease.
Due to
Other Conditions Carcinoma Head of Pancreas.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul R. Ziegler
Address Mercy Hosp. Date signed 4/17/44
M. D.

G 16238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16238

G 16238

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Lemmon St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Lemmon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude L. Hobson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widow

6 (b) Name of husband or wife William Hobson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1883

8. AGE: Years	Months	Days	If less than one day
60	8	17	hr. min

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name William H. Gutermuth
13. Birthplace Baltimore

MOTHER
14. Maiden Name Agnes M. Wakeman
15. Birthplace Baltimore

16 (a) Informant Mrs Agnes Seward
(b) Address 3425 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore
18 (a) Funeral director Frederick Cole
(b) Address 1210 Lombard St
19 (a) [illegible] (b) Registrar Huntington Williams
APR 17 1944

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 13, 1944 at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1944 to 4/15 1944, and that I last saw her alive on 4/13 1944.

Immediate cause of death	Duration
Hypertensive cardio vascular disease	2yrs
Due to	
Due to	
Other Conditions Cerebral Hemorrhage (Include pregnancy within 3 months of death)	1 day

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
M. D.
Address 2030 Wilkens ave Date signed 4/16/44

G 16239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16239 Registered No. 102

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Rural - Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Yorkleigh Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. MASLAND

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or ~~wife~~ Samuel Masland Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1896

8. AGE: Years	Months	Days	If less than one day
47	6	23	hr. min.

9. Birthplace Pennsylvania (Phila.) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name E. G. Conklin
13. Birthplace Ohio

MOTHER
14. Maiden Name Belle Adkins
15. Birthplace Phila. Pa.

16 (a) Informant Mr. Samuel Masland
(b) Address 107 Yorkleigh Rd., Towson, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/18/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 17 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1944, at 9:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1944 to 4-15 1944, and that I last saw her alive on 4-13 1944.

Immediate cause of death: Cardia - respiratory failure
Due to: Essential Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Morris, M.D.
Address [illegible] M. D.
Date signed 4-15-44

G 16240 G 16240 G 162[illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hosp
(c) Hospital or institution: Wilkens Ave & Caton
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4603 Rokeby Rd - 29 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Pfeiffer

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Theresa E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21 1874

8. AGE: Years	Months	Days	If less than one day
70	0	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation grocerman
11. Industry or business Own Business

FATHER
12. Name -- Pfeiffer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Theresa E. Pfeiffer
(b) Address 4603 Rokeby Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 17 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16 1944 at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11/44 19 to 4/16/44 and that I last saw h[illegible] alive on 4/16/44

Immediate cause of death: Acute cardiac failure — Duration
Due to: Coronary Thrombosis
a myocardial infarction
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Infarct of Heart

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bunyan M.D.
Address St Agnes Hosp
Date signed 4/16/44

VS 150

G 16241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16241 Registered No. 131 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 N. Monastery Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2017

3 (a) FULL NAME MARY GRUNER

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1872

8. AGE: Years	Months	Days	If less than one day
71	5	14	hr min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name -- Jacobs
13. Birthplace Unknown

MOTHER
14. Maiden Name - -
15. Birthplace - -

16 (a) Informant Mr. John M. Gruner
(b) Address 101 N. Monastery Ave. 20

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem. Balto., Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 17 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1944 at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1944 to Apr 15 1944 and that I last saw h-- alive on April 15 1944

Immediate cause of death Cardiac Insufficiency — Duration

Due to Chr Nephritis

Due to

Other Conditions Chr. Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur C Manninger M.D.
Address 800 E North Ave Date signed 4/15/44

VS 150

G 16242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G 16242 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 N. onroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRISON L. WOOLFORD, SR.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: May C.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 5, 1886
8. AGE: Years 57 Months 11 Days 9 If less than one day hr min
9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Motorman
11. Industry or business Balto. Transit Co.

FATHER
12. Name Harrison A. Woolford
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Amelia Steinbach
15. Birthplace Balto., Md.

16 (a) Informant Mrs. May C. Woolford
(b) Address 2011 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 17 1944 (Date rec'd by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1944, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1944 to April 14 1944 and that I last saw him alive on April 10 1944.

Immediate cause of death: Carcinoma Oesophagus — Duration: 5 mos.

Due to

Due to

Other Conditions: My records to Oncologist
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
1812 Broadway
Date signed
KOUREY

VS 150

correct age is especially important. Physicians, please write plainly and use only black ink.

AB 87180 G 16243

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

469

G 16243 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 W. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joshua B. Mettam Sr. (Joshua Bartley Mettam, Sr.)

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Florence T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1875

8. AGE: Years	Months	Days	If less than one day: hr	min.
68	8	12		

9. Birthplace Maryland (Balto.) (Town, county, and state)
10. Usual Occupation Retired Salesman
11. Industry or business

FATHER
12. Name Henry E. Mettam (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Bartley
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 17 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April-16- 1944, at 4.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1944 to 4-16 1944, and that I last saw him alive on 4-16 1944.

Immediate cause of death
Bronchopneumonia
Due to Uremia
Due to Carcinoma of Head of Pancreas
Other Conditions

Duration
1 wk
1 wk
8 mos ±

(Include pregnancy within 3 months of death)
Date of operation 4-7-44
Major findings of operation: Ca Head of pancreas
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B. Lebt
Address Balto City Hosp Date signed 4-18-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G 16244 ✓ G 16244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenway Apts - Charles & 34th st. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MARION EDNA LEACH

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife: E. Edwin Leach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1874

8. AGE: Years	Months	Days	If less than one day
69	4 5	28	hr. min.

9. Birthplace Maryland (Harford Co.) (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name James H. Harkins
13. Birthplace Harford Co. Maryland

MOTHER
14. Maiden Name Julia Ward
15. Birthplace Harford Co. Maryland.

16 (a) Informant Mr. E. Edwin Leach
(b) Address Greenway Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) APR 17 1944 (b) Attesting Witness

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1944 at 10:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1944 to 4-15 1944 and that I last saw her alive on 4-15 1944

Immediate cause of death: Cardio respiratory failure
Due to: Toxic Uremia
Due to: Chronic Glomerulo Nephritis — Duration: 7
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 3-12-44
Major findings of operation: Undiagnosed
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Monroe, M.D.
Address Union Mem. Hosp. M. D. Date signed 4-18-44

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Be sure that the information given is correct and complete. Items 20 to 23 are especially important.

16245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16245

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 851 W. 33rd St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Harry Thomas Wright (Grace Darling Wright)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mr. Harry T. Wright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1887

8. AGE: Years 56 | Months 9 | Days 1 | If less than one day: hr. min

9. Birthplace Balto., Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Mr. Charles Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Rees
15. Birthplace Maryland.

16 (a) Informant Mr. Harry T. Wright
(b) Address 851 W. 33rd St., City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19-1944 (month) (day) (year)

(c) Cemetery or crematory West Liberty
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3431 Falls Road

19 (a) Filed APR 17 1944 (b) Date rec'd by registrar — Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944, at 6:34 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1944 to 4-16 1944, and that I last saw her alive on 4-16 1944.

Immediate cause of death Cardio-Respiratory failure — Duration

Due to Cerebral Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Morris, M.D.
M. D.
Address — Date signed 4-16-44

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

16246

83951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G 16246
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 640 N. Fremont Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1914

8. AGE: Years	Months	Days	If less than one day
29	5	18	hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Albert
13. Birthplace Va.

MOTHER
14. Maiden Name Beulah Williamson
15. Birthplace N. C.

16 (a) Informant B. C. H Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs George A. Holland
(b) Address 1651 Druid Hill Ave.

APR 17 1944 (Date received by registrar)

(b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13 1944 at 140P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1943 to 4/12 1944, and that I last saw h alive on 4/12 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mathe M.D.
Address B. C. H. Date signed 4/14/44

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

G 16247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G 16247 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3570 Horton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (Brooklyn)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3570 Horton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sally Ann Boley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. M. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27 1858

8. AGE: Years 86 | Months 32 | Days 19 | If less than one day hr. min

9. Birthplace Lynch Station Va
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name W. P. Hall
13. Birthplace Va

MOTHER 14. Maiden Name Louisa Jane Frazer
15. Birthplace Va

16 (a) Informant John B Boley
(b) Address 3570 Horton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)

(c) Cemetery or crematory Int Herman
Location Altavista Va

18 (a) Funeral director William M Marack
(b) Address 715 Light St

19 (a) Date rec'd by registrar APR 17 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 2 1944 to Apr. 19 .
and that I last saw her alive on 4/15 1944.

Immediate cause of death Pneumonia (Bronchial)

Duration

Due to

Due to

Other Conditions Contributing Factors

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature H H Brown M. D.

Address 1123 S Hanover Date signed 4/17/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FC 16248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Reference No. C 16248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2625 Wash Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 Wash Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E Gibson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Oct 4 1867
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
76	6	10	hr. min

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William H Easley
13. Birthplace Md

MOTHER
14. Maiden Name Winfilda Sippel
15. Birthplace Md

16 (a) Informant Mrs Lane
(b) Address 2625 Wash Blvd

17 (a) Burial (b) Date thereof 4/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director Edward Tawkins
(b) Address 2379 Wash Blvd

APR 17 1944
(Date rec'd by registrar)

19 (a) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 14 1944, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7. 1934, to Apr 14 1944
and that I last saw her alive on Apr 14 1944

Immediate cause of death Coronary Occlusion — Duration 4/6/44

Due to Arteriosclerosis — ?

Due to —

Other Conditions Hypertension — ?

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury —

Signature Carey Rostring M. D.
Address 1316 E Lombard St Date signed 4/15/44

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 94a

G 16249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A. Co.
(c) City or town Baltimore North Linthicum
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5[illegible] Ft. Smallwood
(Actual or customary)
(e) Citizen of foreign country? 156 Annapolis Rd. (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Moog

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-4714

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carrie L. Moog
6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52	8	8		

9. Birthplace Baltimore City, Md. (Town, county, and state)
10. Usual Occupation Cloth Sponger
11. Industry or business

FATHER
12. Name Fred Moog
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Carrie L. Moog
(b) Address 156 Annapolis Rd. G.D. Lo

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schural
(b) Address 525 N. Monroe St.

19 (Date rec'd by registrar) APR 17 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944, at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy / Inspection / Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. R. Wallenmaier M.D.
Medical Examiner.
Date signed April 15, 1944.

VS 151

C 16260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C 16260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 & 6
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Leon Knight

3 (b) If veteran, name war --
3 (c) Social Security Account No. 215-07-3239

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Luticha B. Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1912

8. AGE: Years 32 | Months 0 | Days 15 | If less than one day: hr. min.

9. Birthplace Havre de Grace, Md. (Town, county, and state)
10. Usual Occupation Dispatcher
11. Industry or business Caton Cab. Co.

FATHER
12. Name Leon Knight
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Emma Wilson
15. Birthplace Havre de Grace, Md.

16 (a) Informant Mrs. Luticha B. Knight
(b) Address 1730 Poplar Grove St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) APR 17 1944 (Date received by Registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 15, 1944 at 11.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15th 1944 to April 15 1944 and that I last saw him alive on April 15 1944.

Immediate cause of death: Cerebral Hemorrhage
Left sede Paralysis
Due to Arterial Sclerosis
Due to 240 Blood pressure

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation:

of autopsy: No

Duration: 10 hours

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Robert E. Zapp M. D.
Address 3048 N. Howard St. Date signed 4/17/44

Hunting for Hillsville, Md

16251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G 16251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 63 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town MARYLAND (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 SOUTH WAY (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME EDNA JONES DENNIS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife THOMAS J. DENNIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-13-1880

8. AGE: Years 63 | Months 10 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace FREDERICK CO, MARYLAND (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name DORSEY JONES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name CORNELIA HAMMOND
15. Birthplace MARYLAND

16 (a) Informant THOMAS J. DENNIS
(b) Address 409 Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Fairmount
Location Libertytown Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

APR 17 1944

(b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1944, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1944 to 4-15 1944, and that I last saw her alive on 4-15 1944

Immediate cause of death CARDIO RESPIRATORY FAILURE — Duration 3 YEARS

Due to CARCINOMA OF BREAST & GENERALIZED METASTASES

Due to

Other Conditions PATHOLOGICAL FRACTURE OF RIGHT FEMOR
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence August 12, 1944 at 2 30 P. M.
(c) Where did injury occur? 409 Southway (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home (Specify type of place) While at work? no
(e) Means of injury Fell to floor on way to bathroom

23. Signature Stephen J Van Lill M.D.

Address Union Memorial Hosp Date signed 4-15-44

Approved by Howard J. Masters, M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16253 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1442 MARSHALL ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1442 MARSHALL ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY. C. STRICKER.

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 705-12-3789

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARTHA L. STRICKER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB-5-1886

8. AGE: Years 58 | Months 2 | Days 10 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation CARMAN.

11. Industry or business B+O RR.

FATHER
12. Name ANTON STRICKER
13. Birthplace GERMANY.

MOTHER
14. Maiden Name MARGARET, KROEGER
15. Birthplace GERMANY.

16 (a) Informant MARTHA. L. STRICKER
(b) Address 1442 MARSHALL. ST

17 (a) BURIAL (b) Date thereof 4-18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A A Co.

18 (a) Funeral director Bernard C Hank
(b) Address 121 E West St

APR 17 1944
(Date rec'd by registrar)

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 15 1944 at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943 to April 12 1944 and that I last saw h[illegible] alive on 4-12- 1944

Immediate cause of death: Heart failure — Duration:

Due to Myodegenerative [illegible], — Duration:

Due to Coronary [illegible] — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R.W. Weinberger
Address 102 E. Fort Ave Date signed 4-17-44 M. D.

Huntington Williams, M.D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16253 FRAIDEN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G 16253 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital of Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 719 Lake Drive
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Corleys Apts 3 ER. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Frieden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 45 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Hebrew School Teacher

11. Industry or business

FATHER
12. Name Jacob Fraiden
13. Birthplace Russia

MOTHER
14. Maiden Name Nadya
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Pikesville Md Reisterstown Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) APR 17 1944 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17/1944, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28/1944 to 4/17/1944 and that I last saw her alive on 4/16/1944.

Immediate cause of death: Cardiac Failure

Due to Generalized carcinoma 2° to Breast Ca.

Due to Sarcoma of Uterus?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Murray Levine, M.D.
Address Sinai Hosp. Date signed 4/17/44

correct age is especially important. Physicians: please write plainly and use only accepted abbreviations. Avoid use of ditto marks.

VS 150

G 16254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164a

G 16254
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 E. Chester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack H. Glazerow

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	School-boy

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1929

8. AGE: Years	Months	Days	If less than one day
15			hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation School Boy
11. Industry or business

FATHER
12. Name Max Glazerow
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Germans Hill Rd.

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Balto St

19 (a) APR 17 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16- 1944, at 6 45 A M

21. I certify that I took charge of the remains described above, held an Autopsy - Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Hanging
Other Conditions Suspension
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-16- at A M.
(b) Where did injury occur? 23 E. Chester Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suspended by neck-Tie

23. Signature Howard J. Mallett M.D.
Medical Examiner.
Date signed 4-16-44

Huntington Williams M.D.

G 6255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

GG [illegible] Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2114 E. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 E Balto St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Selig Berkowitz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Hungary (town, county, and state)
10. Usual Occupation Ship yard
11. Industry or business

MOTHER / FATHER
12. Name Ezra
13. Birthplace Hungary
14. Maiden Name Chas
15. Birthplace Hungary

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St
18 (a) Funeral director Jack Langlum
(b) Address 1439 E. Balto St

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16 1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1944 to April 16 1944 and that I last saw h[illegible] alive on April 16 1944.

Immediate cause of death
Coronary Thrombosis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 5 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon
Address 129 S. Broadway Date signed 4/16/44 M.D.

vs APR 17 1944 for Robt. Jr. Graham, by Howard L. Merrin, M.D.

correct age is especially important, and should be given in all cases where obtainable.

G 16256

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16256

Registered No. 161c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: U M H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto., Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Belgain Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-44

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Edward Joseph Mead Jr
13. Birthplace Maryland

MOTHER
14. Maiden Name Margt. Flaherty
15. Birthplace Wisconsin

16 (a) Informant History
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Old Frederick Rd.

18 (a) Funeral director John A. Moran
(b) Address 3010 E. Balto St.

19 (a) APR 17 1944 (Date received by registrar)
Thurlington Williams, M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15-44 19 , at 2.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 19 44 to 4-15 19 44 and that I last saw him alive on 4-15 19 44.

Immediate cause of death Cardio — Respiratory failure — Duration

Due to Erythroblastosis fetalis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: Edema pericardial & pleural fluid — Enlarged [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following to.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed Morris, M.D. M. D.
Address U M H. Date signed 4-15-44

G 16257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 96

G 16257

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St
(c) Hospital or institution:
Hospital For Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 YRS?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apartments
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Matilda Worthington RUTH MATHILDA WORTHINGTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Howard Smith Worthington
6 (c) If widow or widower, age 43 years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45	11	28/8		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Clerk-OPA
11. Industry or business

FATHER
12. Name John T Simpkins
13. Birthplace Solomons Island Md

MOTHER
14. Maiden Name Bertha M. Fields
15. Birthplace Salisbury Md

16 (a) Informant Howard S. Worthington
(b) Address Ambassador Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 17 1944 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 14th 1944, at 8:56 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 12 1944, to APRIL 14 1944, and that I last saw her alive on APRIL 14 1944.

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to ANEURYSM (CONGENITAL) CEREBRAL VESSEL	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Unable to obtain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature Newland Edward Day M. D.
Address Hospital for Women, Md. Date signed 4-14-44

(OVER)

VS 3

G 16258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G 16258 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 Homestead St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County - - -
(c) City or town Baltimore -18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Homestead St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN THOMAS HAMMEN SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Georgianna Hammen
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Mar.10.1851

8. AGE: Years	Months	Days	If less than one day
93	1	5	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Retired

FATHER
12. Name Michael J.Hammen
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M.Atwell
15. Birthplace Eastern Shore, Md.

16 (a) Informant John T. Hammen Jr. (Son)
(b) Address 1722 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr.17.1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway.

19 (a) APR 17 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

correct age is apparently impossible

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr.15.1944 at 2.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/L - 19 , to 4/15 - 1944 and that I last saw [illegible] alive on 4/14/1944.

Immediate cause of death Myocardial Degeneration Duration 1 yr.

Due to Arteriosclerosis

Due to Old age

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. Hammen M. D.
Address 1715 E 33rd St Date signed 4/15/44

G 16259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G 16259 Registered No. 2098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 W. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Calhoun St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Sarah Scott

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-6247

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife James Scott
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1898

8. AGE: Years	Months	Days	If less than one day
46	2	3	hr. min.

9. Birthplace Calvert Co. Md (Town, county, and state)
10. Usual Occupation Laundry Worker
11. Industry or business Regal Laundry

FATHER 12. Name John Cook
13. Birthplace Calvert Co Md

MOTHER 14. Maiden Name Martha Thomas
15. Birthplace Calvert Co. Md

16 (a) Informant Mrs Maggie Freeman
(b) Address 1517 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. U. Kelbaugh
(b) Address 1303 Presstman St

19 (a) Date received by registrar (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 — 15 — 1944 at 3:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1943 to 4-15 1944, and that I last saw her alive on 4-14 1944.

Immediate cause of death — **Duration**

Nephritis — Unknown
Due to Unknown
Due to
Other Conditions Pneumonia — Unknown
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St Date signed 4-15-44

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

~~G-16260~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~G-16260~~ Registered No. 124B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 31 S. Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Amelia Barbini
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Dante
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Dec. 18 1888

8. AGE: Years 55 | Months 3 | Days 27 | If less than one day hr. min

9. Birthplace Italy (Town, county and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Pasquale Firenzzoni
13. Birthplace Italy

MOTHER
14. Maiden Name Frances Ghaffiz
15. Birthplace Italy

16 (a) Informant Dante Barbini
(b) Address 31 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 19 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd.

18 (a) Funeral director Mahr & Sipple Sons
(b) Address 37 S Ann St

19 (a) (b)
APR 17 1944
Huntington Williams, Mitt

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~April~~ 2/7 19 44, to 4/15 1944, and that I last saw h~~im~~er alive on 4/15 1944.

Immediate cause of death Coronary Heart failure — Duration

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H E. Watkins M. D.
Address 1400 N. Caroline St Date signed 4/15/44

VS 150

Please answer all questions carefully and legibly. Physicians: please write the causes of death clearly and legibly.

C 16261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49c

C [redacted] Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 S. East Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 61

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 S. East Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Bohle

3 (b) If veteran, name war | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Conrad
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8 1867

8. AGE: Years 77 | Months | Days 7 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation
11. Industry or business At. Home

FATHER
12. Name Valentine Reit
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schwartz
15. Birthplace Germany

16 (a) Informant Anna B. Love
(b) Address 2917 Woodland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 17 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Mathias C. Appel Sons
(b) Address 378 Cathedral St.

19 APR 17 1944 Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944, at 4:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1944 to April 15 1944, and that I last saw her alive on Apr 15 1944.

Immediate cause of death	Duration
Cardio Respiratory paralysis	8 mos.
Due to Aneurysm Aorta	
General Abdominal	2 & 3 mos.
Due to Carcinomatosis	
Rectal & Vaginal	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Clift
Address 5010 Greenleaf Rd Date signed 4/16/44

G 16262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 16262 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) D - o - A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 N Calvert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Steve Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03 2798

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 44 | Months | Days | If less than one day: hr. | min.

9. Birthplace Oklahoma City, Oklahoma (Town, county, and state)

10. Usual Occupation Shop-Fitter

11. Industry or business Bethlehem-Fairfield

FATHER
12. Name Willard A Davis
13. Birthplace North Carolina

MOTHER
14. Maiden Name Sarah Collins
15. Birthplace

16 (a) Informant Sylvester Davis
(b) Address 865 Park Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-17-44 (month) (day) (year)
(c) Cemetery or crematory Charlotte N.C.
Location Williamson Cook Co.

18 (a) Funeral director 127 Cx6 and St
(b) Address

19 (a) APR 17 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15- 19KK, at 2-15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ Probably, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-15- at 11/1 P. M.
(b) Where did injury occur? 606 N. Calvert Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating Gas range

23. Signature Howard J. Madeira M.D. Medical Examiner

Date signed 4-16-44

VS 151

G 16263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16263
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Shields Alley
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Walter Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband or wife: Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1900

8. AGE: Years: 43 | Months: 7 | Days: 11 | If less than one day: hr min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Shipyard Worker
11. Industry or business Bethlehem-Fairfield

FATHER
12. Name Chas Tyler
13. Birthplace Va.

MOTHER
14. Maiden Name Helen Green
15. Birthplace Md.

16 (a) Informant Carl Green (Bro.)
(b) Address 730 W Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md.

18 (a) Funeral director Charles S. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) APR 17 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1944, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobar bilateral

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner
Date signed April 12, 1944.

VS 181

G 16264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G 16264 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 53½ N Calvert

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. yrs., mos., or days 23 days

(e) Length of stay in Baltimore yrs., mos., or days LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RFD and give town)

(d) Street No 4305 Wendover Rd. (If rural give location)

(e) Citizen of foreign country? no Yes or No

If yes, name country

3 (a) FULL NAME MR. WARREN K. MAGRUDER (Warren Keach Magruder)

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs Mary Magruder

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): 2-8-1889

8. AGE: Years 57 | Months 2 | Days 7 | If less than one day: hr min

9. Birthplace: BALTIMORE, Md (Town, county, and state)

10. Usual Occupation: Life insurance agent

11. Industry or business: Mutual Life Ins Co.

FATHER

12. Name: Mr Edward B. Magruder

13. Birthplace: Washington, D.C

MOTHER

14. Maiden Name: Annie M. Keach

15. Birthplace: BALTIMORE, Md

16 (a) Informant: Admission history

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr-17-44 (month) (day) (year)

(c) Cemetery or crematory: Greenmount

Location: Baltimore

18 (a) Funeral director: STEWART & MOWEN COMPANY

(b) Address: (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH april 15 1944 at 5 20/A M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 24 1944 to April 15 1944, and that I last saw h IM alive on April 15 1944.

Immediate cause of death Cardio - Resp FAILURE — Duration: 2 yrs.

Due to Arterio sclerotic Heart Disease

Due to

Other Conditions Diabetes Mellitus — Duration: 12 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George W. Magruder Jr. M D

Address 332 E University Pkwy Date signed 4/15/44

16265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Curtis Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shrout
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 4-15-44
8. AGE: Years | Months | Days | If less than one day: hr min
1 2
9. Birthplace: Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hubbard Shrout
13. Birthplace W. Va.

MOTHER
14. Maiden Name Norma J. Hornbeck
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location (city or town) (county) (state)

APR 20 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

APR 17 1944 (a) (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 17 1944, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 15 1944 to Apr 17 1944, and that I last saw HIM alive on Apr 17 1944.

Immediate cause of death: Resp. failure — Duration
Prematurity
Lung atelectasis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
I underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson, M.D.
Address Johns Hopkins Hosp. Date signed 4-17-44

G 16266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16266

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3703 Claremont St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3703 Claremont St.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Georgiana B. Cicone

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John N. Cicone

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 12 1898

8. AGE: Years	Months	Days	If less than one day: hr.	min
45	9	4		

9. Birthplace Indiana
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER

12. Name David Johns

13. Birthplace Indiana

MOTHER

14. Maiden Name Mary Alice ?

15. Birthplace ?

16 (a) Informant Boby Cicone

(b) Address 3703 Claremont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19/44 (month) (day) (year)

(c) Cemetery ~~xxxxxxxx~~ Holy Redeemer Cem.

Location Belair Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Morley St.

APR 17 1944

19 (a) ____ (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-44 ~~19~~, at 1.30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 1-30 1943, to 4-16-1944, and that I last saw h[illegible] alive on 4-15-1944.

Immediate cause of death: Cerebral thrombosis

Due to: [illegible] coronary disease

Due to: ____

Other Conditions: Diabetes

(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: ____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)

(e) Means of injury ____

23. Signature [illegible] M.D.

Address 2 3Y [illegible] Date signed 4-17-44

G 16267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 937

G 16267 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Morton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Unmarried

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1891

8. AGE: Years 52 53 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name William Morton
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Lawson
15. Birthplace Va.

16 (a) Informant Daisy Walker
(b) Address 160 E. Eager St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 17 44 (month) (day) (year)

(c) Cemetery or crematory
Location Meherrin Virginia

18 (a) Funeral director Mrs. Robert O. Elliott & Dept.
(b) Address 1129 N. Carlton St.

19 (a) [illegible] Huntington Williams, M.D. Registrar

APR 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1944, at 2A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner
Date signed April 17, 1944

Dr. Paul Brown
1663 West North Ave.

16268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G 16268
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Milford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Milford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Bentz

3 (b) If veteran, name war ---------

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Sarah Ellen Bentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1857

8. AGE: Years	Months	Days	If less than one day
86	9	9	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Retired Painter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Sarah Ellen Sohl
(b) Address 3814 Milford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18, 44 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore, Maryland

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) Date received APR 17 1944 (registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 15 1944 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1943 to Apr 15 1944 and that I last saw h alive on Apr 15 1944.

Immediate cause of death Chr. Myocarditis — Duration 1935

Due to Arteriosclerosis — 1935

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Brown M. D.
Address 1663d North Ave Date signed 4/17/44

G 16269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 98

G 16269 (Registered No.)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk.
(e) Length of stay in Baltimore (yrs., mos., or days) not known

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES GRANT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) not known

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace not known (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden Name not known
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-44 (month) (day) (year)
(c) Cemetery or crematory Brooks Chapel
Location Catonsville Md

18 (a) Funeral director P. E. Lewis
(b) Address Princess Frederick Md

APR 17 1944 (Date received by Registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16 19 44 at 6 05 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 19 44 to 4-16 19 44 and that I last saw him alive on 4-16 19 44

Immediate cause of death: Pulmonary tuberculosis

Duration

Due to Tuberculosis of lung

Due to

Other Conditions Hypertension - arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David K. Horgan
Address University Hospital Date signed 4/16/44 M.

G 16270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G G 16270 Registered No.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D&A Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto J. Writesman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife: Beulah Writesman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/1886

8. AGE: Years 57 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace Nashville, Tenn (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Merchant Marine

FATHER 12. Name J. A. Writesman

FATHER 13. Birthplace Nashville Tenn

MOTHER 14. Maiden Name Georgia A. Thompson

MOTHER 15. Birthplace Nashville Tenn

16 (a) Informant Mrs Chas White

(b) Address 107 W. 26th Ave, Tampa, Fla

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/17/44 (month) (day) (year)

(c) Cemetery or crematory

Location Tampa, Florida

18 (a) Funeral director Wm. J. Sexauer Sons

(b) Address North & Ra. Aves

19 (a) APR 17 19 (Date rec'd by registrar) (b) Huntington Williams Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1944, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.

Date signed 4/17/44.

Over

VS 151

G 16271 4-5-1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16271
Registered No.

1192

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Rd 16. Box 142 Hopewell ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Baby Boy "A" Lingham
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race Black
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3-28-44
8. AGE: Years Months Days 17 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

MOTHER / FATHER
12. Name Vernon Lingham
13. Birthplace Md.
14. Maiden Name Elsie Turky
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MED. SCHOOL APR 17 1944
Commissioner of Health

18 (a) Funeral director Huntington Williams, M.D.
(b) Address
19 APR 17 1944 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944 at 10 11 M

21. I certify that death occurred on the date above stated, that I attended deceased from Mar 28 1944 to April 14 1944 and that I last saw him alive on April 14 1944

Immediate cause of death
respiratory failure — Duration 1 minute
Due to prematurity — 17 days
Due to
Other Conditions diarrhea.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M. D.
Address Johns Hopkins Hosp. Date signed 4-14-44

VS 150

0878

G 16272

AB-84971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G-16272
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr-9 mos.-21 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1414 Eutaw Place
(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William L. Koeneke

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-1333

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 11-1872

8. AGE: Years	Months	Days	If less than one day
71	4	5	hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation (Truck driver

11. Industry or business

FATHER

12. Name ? Koeneke

13. Birthplace Md.

MOTHER

14. Maiden Name ?

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Apr 19/44
(month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore County

18 (a) Funeral director Philip Hennig's Sons

(b) Address 1824 Eastern Ave

19 (a) Hampden-Williams, M.R (b) .....
(Date received by registrar) Registrar

APR 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April-16 1944 at 4.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1942 to 4-16 1944 and that I last saw h[illegible] alive on 4-16 1944.

Immediate cause of death	Duration
Cerebral Thrombosis	1
Due to (a) Right Hemiplegia	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at .... M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury .....

23. Signature Paul Mattina

Address B.C.H

Date signed 4/16/44
M. D.

GG16273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 16273

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Woodbourne (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Henry Goeken
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 18[illegible] 1

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Newark - N. J. (town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Henry F. Goeken
13. Birthplace Lancaster, Pa.

MOTHER
14. Maiden Name Catherine Haberbush
15. Birthplace Lancaster Pa.

16 (a) Informant Elizabeth Goeken
(b) Address 903 Woodbourne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4- -44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Lancaster, Pa.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) [illegible] Huntington Williams M.D. Registrar
APR 17 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16; 1944, at 9 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1944 to 4-16 1944 and that I last saw h[illegible] alive on 4-16 1944.

Immediate cause of death Acute Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph's Hospital Date signed 4-16-44

22521 G 16874 G 16272 G 16274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Parkside Drive (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Gertrude Klingenberg

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife LOUIS C.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 10-1-1884

8. AGE: Years	Months	Days	If less than one day
59 54	6	14	hr. ..... min.

9. Birthplace Pa. - Adams Co. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business .....

FATHER
12. Name Andrew McKinney
13. Birthplace Pa.

MOTHER
14. Maiden Name Laura Hinkle
15. Birthplace Pa

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5303 Harford Rd.

APR 17 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944, at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1944, to April 15 1944, and that I last saw HER alive on April 15 1944.

Immediate cause of death	Duration
VENTRICULAR FIBRILLATION	
Due to ARTERIOSCLEROTIC HEART DISEASE	4 yrs.
Due to GENERALIZED ARTERIO-SCLEROSIS	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Wm. S. Speed III M. D.
Address Johns Hopkins Hosp. Date signed 4-15-44

C 16275

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 16275
Registered No. 1702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5010 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grady N. Yarborough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26-1922

8. AGE: Years	Months	Days	If less than one day
22	1	19	hr. min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation machinist

11. Industry or business

FATHER 12. Name Grady L. Yarborough
13. Birthplace Tenn.

MOTHER 14. Maiden Name Opal Hammond
15. Birthplace Tenn.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-44 (month) (day) (year)

(c) Cemetery or crematory
Location Sheffield Mausoleum

18 (a) Funeral director Leonard J. Ruck
(b) Address 1005 Wayland Rd.

APR 19 1944

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1944 at 5:50 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death, in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Fracture of skull

due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-14-44 at 5:30 P. M. 6-1
(b) Where did injury occur? E. Lloyd Ave. & Fairmount Avenue.
(c) Did injury occur at home, on farm, industrial place, in public place? Public (While at work?) No
(d) Means of injury a motor driven truck driven by a motorman.

23. Signature H. J. Wollenmuller M.D. Medical Examiner.
Date signed April 15, 1944.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JO [illegible] G 16276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16276 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos. 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Leroy Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 249-05-9645

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1905

8. AGE: Years	Months	Days	If less than one day
38	10	6	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Alvin Johnson
13. Birthplace South Carolina

MOTHER
14. Maiden Name Virginia Reeves
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location [illegible]

18 (a) Funeral director Byron Hamrick H. Vaught
(b) Address 727 Edgewood St

19 (a) APR 17 1944 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1944, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1943. to 4-14 1944. and that I last saw h[illegible] alive on 4-14 1944.

Immediate cause of death [illegible] Pulmonary tuberculosis

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible]

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 4-15-44

Please write plainly; especially important. Physicians: please write the causes of death clearly and legibly.

G-16277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G-16277 V 1214

Registered No. 42202

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkins Ave

(c) Hospital or institution: ST. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Arbutus. (If outside city or town limits, write RURAL and give town)

(d) Street No. 5640 Carrollton Av. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Catherine Doughty

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-9680

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thos. L. Doughty

6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Mar 21-1907

8. AGE: Years: 37 Months: 1 Days: 13 If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Secretary.

11. Industry or business

FATHER 12. Name: Geo. C. Franklin

13. Birthplace: Maryland

MOTHER 14. Maiden Name: Catherine Reardon

15. Birthplace: Maryland

16 (a) Informant: Mrs. Franklin Wolfe

(b) Address: 3702 Edmondale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19-44 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral

Location: Frederick Rd

18 (a) Funeral director: John R Kenny

(b) Address: 1242 Lead Ter, Arbutus, Md.

19 (a) Date received: APR 17 1944 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1944 to 4/15 1944, and that I last saw her alive on 4/15 1944.

Immediate cause of death: Cyanosis

Due to: Pneumonitis

Due to:

Other Conditions: Hypertensive Cardio-Renal disease

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: H. Gilmer Rawlings M.D.

Address: St. Agnes Hosp. Date signed: 4/15/44

451853 G 16278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G 16278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington S.W. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Suitland Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Clair Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-81

8. AGE: Years	Months	Days	If less than one day
63	3	7	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Truck farmer
11. Industry or business

FATHER
12. Name William A. Harrison
13. Birthplace Va.

MOTHER
14. Maiden Name Saphroni Douglas
15. Birthplace Va.

16 (a) Informant Recds
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof april 20-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Suitland, Maryland

18 (a) Funeral director Thomas F. Murray D.C.
(b) Address 2207 - Nicholson Ave S.E. Wash

19 (a) 4/17/44 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 44 at 12 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 19 44 to April 17 19 44 and that I last saw him alive on April 17 19 44.

Immediate cause of death Uremia — Duration

Due to Carcinoma of Prostate with

Due to metastases.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell R. Roth M.D.
Address Johns Hopkins Hosp Date signed 4/17/44

VS 180

G 16279 G 16279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 O'Donnell Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 O'Donnell Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME August Kiefer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret B. Henshaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1873

8. AGE: Years	Months	Days	If less than one day
71		8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Louis Henshaw
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Fredericka Helm
15. Birthplace Baltimore, Maryland

16 (a) Informant Wife
(b) Address 3308 O'Donnell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) April 19 (b) (Date received by registrar)

APR 17 1944

Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 2 1943 to April 16 1944 and that I last saw her alive on Apr 15 1944.

Immediate cause of death Coronary Thrombosis — Duration 4/13/44

Due to Chr. Myocarditis — 4/2/43

Due to Hypertensive Cardio Vascular Disease — 1940

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Roemer M. D.
Address 844 N Kenwood Ave Date signed 4/17/44

1631 E. Fa. 16280

BALTIMORE CITY HEALTH DEPARTMENT G 16280 Registered No.

CERTIFICATE OF DEATH 92D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution:
Little Sisters of the Poor 1D
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Grossman

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 4 1895

8. AGE: Years	Months	Days	If less than one day
49	3	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Friedrich
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Irwin
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 18/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler INC
(b) Address 403 S. WOLFE ST.

19 (a) (b) Huntington Williams M.D. Registrar

(Date received by registrar) APR 17 1944

MEDICAL CERTIFICATION 2.30 p

20. DATE OF DEATH April 15 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 - 1944, to April 15 1944, and that I last saw him alive on April 15 1944.

Immediate cause of death	Duration
Acute Dilatation of Heart	3 days
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E Gill Hall M. D.
Address 1631 North ave Date signed 4/16/44

2604 E. Baltimore St

G 16280

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 F

G 16280 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 S. EATON ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. EATON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME ANNA KLEINHENN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife HENRY KLEINHENN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 11 1893

8. AGE: Years	Months	Days	If less than one day
50	7	4	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name LOUIS HOFER
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MINNIE HESSE
15. Birthplace BALTO. MD.

16 (a) Informant HENRY KLEINHENN (HUS.)
(b) Address 620 S. EATON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 18/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

APR 17 1944 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH APR. 15 1944 at 11/45

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to April 14 1944.
and that I last saw her alive on April 14 1944.

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to Lymphatic + blood stream infection	16 months
Due to Carcinoma of breast + left axilla	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jan 1943
Major findings of operation: sarcoma
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Mazer M.D.
Address 604 E. Baltimore St Date signed 4/16/44

MAZER

VS 150

G 1628 Forest — BALTIMORE CITY HEALTH DEPARTMENT — G 16282 Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & Slat St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 4/10/44
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 750 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME FRED EDWARD KLIMPER

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bertha Krohn
6 (c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.) 10/16/1898
8. AGE: Years 45 | Months 6 | Days 1 | If less than one day: hr. min.
9. Birthplace Cincinnati, Ohio (Town, county, and state)
10. Usual Occupation Pipefitter 12/43
11. Industry or business

FATHER
12. Name Fred Klimper
13. Birthplace Cincinnati, Ohio

MOTHER
14. Maiden Name Helen Reinrs
15. Birthplace Cincinnati, Ohio

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-44 (month) (day) (year)
(c) Cemetery or crematory Locust Point National Cemetery
Location Baltimore, Md.

18 (a) Funeral director Lilly and Carter 1/4
(b) Address 4035 W. Wolfe St. Huntington Williams, M.R.

APR 17 1944 (Date accepted by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1944, at 8:05 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 10, 1944 to Apr. 17, 1944, and that I last saw him alive on Apr. 17, 1944.

Immediate cause of death: 1. Left cerebral hemorrhage with large left subdural hematoma. 2. Rt. lower xxxx bronchial pneumonia
Due to
Due to
Other Conditions
(Include pregnancy within three months of death)

Duration: Unk. / Terminal

Date of operation: 4/10 & 4/11/44
Major findings of operation: Bloody fluid removed. 6 Burrel Punctures made
Findings of autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. Caswell
Address Baltimore, Md. Date signed 4/19/44

VS 150

Va-14415

16283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G 16283
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3515 Spaulding Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 Spaulding Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Catharine Rebecca Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John B. Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 23, 1867

8. AGE: Years	Months	Days	If less than one day
77 yrs	0	23	hr. min.

9. Birthplace Hanover, Penna.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Pius Breighner
13. Birthplace Penna.

MOTHER
14. Maiden Name Anna Crisler
15. Birthplace Penna

16 (a) Informant Mrs. Irene Gerndt
(b) Address 3515 Spaulding Ave.

17 (a) Burial (b) Date thereof 4-19-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Jospeh's Cemetery
Location Hanover, Penna.

18 (a) Funeral director La Vernon Lemmon
(b) Address 4611 Park Hgts. Ave.

19 (a) APR 18 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1944 at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from APR 5 1944 to Apr. 16 1944, and that I last saw her alive on Apr. 16 1944.

Immediate cause of death: Uremic Sclerosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. D. Bubert M. D.
Address 4803 Park Hgts. Date signed 4/17/44

VS 8

G 16284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

G 16284 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. a. D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 E. Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank D. Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Harford Co (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business J. Hopkins, Wyman Park

FATHER
12. Name John Miller
13. Birthplace Harford Co

MOTHER
14. Maiden Name Anastasia Harvey
15. Birthplace Unknown

16 (a) Informant Mrs S. T. Hudson
(b) Address Route 2, Parkway N. Towson

17 (a) Cathedral Lntz (Burial, cremation, or removal) (b) Date thereof 4-19-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location —

18 (a) Funeral director Mary Mc Wiedefeld
(b) Address 524 E. 22nd St

19 APR 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944, at 8:25 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 17, 1944

G 16285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

G 16285 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5006 Queensbury Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Queensbury Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Isaacson

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-9022

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 10, 1913

8. AGE: Years 30 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Cashier Nutzlers Dept Store

FATHER
12. Name Sam Isaacson
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Lebowitz
15. Birthplace Russia

16 (a) Informant Sam Isaacson
(b) Address 5006 Queensbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April. 17, (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 APR 18 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1942 to April 17 1944 and that I last saw her alive on April 17 1944.

Immediate cause of death
Brain tumor - malignant involving left parietal lobe
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration
6-1-42 to 4-17-44

Date of operation Oct 17, 1943
Major findings of operation:
Cancer brain
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton G. Lowman M. D.
Address 5013 Park Heights Ave Date signed 4-17-44

16286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16286
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2227 Woodland~~
(c) Hospital or institution: Sinai Hosp, Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Pitman Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Shapoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	white	married

6 (b) Name of husband or wife Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16 1893

8. AGE: Years	Months	Days	If less than one day
51	-	-	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Grocery Store

11. Industry or business

FATHER
12. Name Harry Shapoff
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Siegel
15. Birthplace Russia

16 (a) Informant Nettie Shapoff
(b) Address 423 Pitman Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/44 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cemetery
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

APR 18 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1944, at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15/1944 to 4/16/1944, and that I last saw him alive on 4/16/1944.

Immediate cause of death	Duration
circulatory collapse	
Due to Coronary occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Murray Semes, M.D.
Address Sinai Hosp - Date signed 4/16/44

VS 180

6287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16287
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 S.Lehigh St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 S.Lehigh (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin H.Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-8379

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Addie B.Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1883

8. AGE: Years	Months	Days	If less than one day hr.	min.
61	1			

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business Penn.R.R.

FATHER
12. Name Henry Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Addie H.Smith
(b) Address 531 S.Lehigh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 22 S Jefferson St.
(c) Filed APR 18 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15/44 19 44, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940, to 4/16 1944, and that I last saw him alive on 4/15 1944

Immediate cause of death	Duration
Thrombosis	12 hrs.
Due to Arteriosclerosis	3 yrs.
Due to Diabetes Mellitus	4 yrs.
Other Conditions: Hypocardial Degen. Coronary Thr.	4 yrs.
Some pain + Chr. bronchitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury
23. Signature O. H. Greenberg
Address 161 S Eastern Date signed 4/17/44

16288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G 16288
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7215 Plainveiw Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. yrs., mos., or days 26
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7215 Plainveiw Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Kriss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Annie M. Kriss
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr July 1867

8. AGE: Years 76 | Months 9 | Days 1 | If less than one day hr min

9. Birthplace **Astr** Austria
(Town, county, and state)

10. Usual Occupation Excavator
11. Industry or business

FATHER
12. Name Charles Kriss
13. Birthplace Austria

MOTHER
14. Maiden Name Catherine Sedlak
15. Birthplace Austria

16 (a) Informant Anton C. Kriss
(b) Address 1601 O, Dell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date then April 18/44 (Month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Horner & Lane

18 (a) Funeral director John G. Miller
(b) Address 2334 Jefferson St.

APR 18 1944
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944, at 11.0 M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 15 1944, to April 2 1944, and that I last saw him alive on April 14 1944

Immediate cause of death: Cerebral apoplexy — Duration: 3 days

Due to Arteriosclerotic Cardio-Vascular disease

Due to With hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo M. Baumgardner M. D.
Address 3256 Brd Date signed 4/17/44

G 16289
43-2175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92D

G 16289
Registration No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

3 V

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore
(If rural, give township)
(c) Street No. 917 E. Lombard St.
(If rural, give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Richard Finley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr August 2, 1864
8. AGE: Years 79 | Months 8 | Days 15/30 | If less than one day hr min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Finley
13. Birthplace ✓

MOTHER
14. Maiden Name Unknown
15. Birthplace ✓

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 4/18/44 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cemetery
Location O'Donnell St.
18 (a) Funeral director Harry N. Blight, Jr.
(b) Address 4914 Belair Road
19 (a) Huntington Williams, M.D. Registrar

APR 18 1944

MEDICAL CERTIFICATION

34

20. DATE OF DEATH April 12 1944 at 10 A M
21. I certify that death occurred on the date above stated, that I attended deceased from April 6 1944 to April 12 1944 and that I last saw him alive on April 9 1944.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Cerebral thrombosis due to cardiovascular disease	
Due to:	
Other Conditions: auricular fibrillation	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Abraham Cenecin
Address U. Hospital Date signed 4-13-44

Please write the causes of death clearly and legibly. Physicians: especially important.

G 16290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G 16290 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3911 PARK HEIGHTS AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 PARK HEIGHTS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILLIP LIPSKY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 1879

8. AGE: Years 65 | Months | Days | If less than one day hr min

9. Birthplace RUSSIA. (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Russia

MOTHER 14. Maiden Name Rose

15. Birthplace Russia

16 (a) Informant JENNIE LIPSKY - DAU.-IN-LAW

(b) Address 134 S. GILMOR ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-18-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale Location Phila Rd & Hamilton Ave

18 (a) Funeral director JACK LEWIS INC.

(b) Address 1439 E. BALTO. ST.

19 APR 18 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16- 1944, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 1944, to April 15 1944, and that I last saw him alive on April 16, 1944

Immediate cause of death Hypertensive cardio-vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis T. Lavy

Address 844 W. Mt. Ave. Date signed 4/18/1944

16291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16291
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 North Carey
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Mount (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Dingess

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Samuel Dingess | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 72 | Months | Days | If less than one day hr. min

9. Birthplace Hamilton Co. Va
(Town, county and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name Emmanuel Pollard
13. Birthplace Va

MOTHER
14. Maiden Name Catherine
15. Birthplace Va.

16 (a) Informant Edward Lantz
(b) Address 107 North Carey

17 (a) Burial (b) Date thereof 4/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14/44 19 , at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14/44 to 4/14/44 and that I last saw the alive on 4/14/44

Immediate cause of death Cerebral Hemorrhage

Duration 2 hrs

Due to General arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature H. C. Reiss M. D.
Address 824 North Carey Date signed 4/18/44

16292

452502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16292

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 W Monument (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Harris
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lucius
6 (c) If alive, give age: 48 years

7. Birth date of deceased mo., day, yr.: 5-4-98

8. AGE: Years: 45 | Months: 11 | Days: 10 | If less than one day: hr ___ min ___

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: James Parraway
13. Birthplace: Md

MOTHER
14. Maiden Name: Bertha Stewart
15. Birthplace: Md

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/44 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial
Location: Halethorp, Md

18 (a) Funeral director: Charles R. Law
(b) Address: 802 Madison ave.

19 (a) (Date rec'd by registrar) APR 18 1944 (b) Huntington Williams, M.D.

VS 15a

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 14 1944, at 9:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Apr 12 1944, to Apr 14 1944, and that I last saw her alive on Apr 14 1944

Immediate cause of death: Cardiac failure — Duration:

Due to: Respiratory embarrassment

Due to: Malaria, subdiaphragmatic pressure of myomatous uterus

Other Conditions: Cachexia due from 2 months sections

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None.

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

23. Signature: Marion N. Davis, M.D.
Address: J.H.H.
Date signed: 4-15-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

16293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V. G 16293 Registered No.

SB-86237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rosa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25- 1912

8. AGE: Years 31 | Months 3 | Days 21 20 | If less than one day hr min

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name James Taylor

13. Birthplace N.C.

14. Maiden Name ?

15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. Co., Md.

18 (a) Funeral director Charles L. Law

(b) Address 802 Madison Ave.

19 (a) (Date received) APR 18 1944 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29 1944 to 4-15 1944, and that I last saw h[illegible] alive on 4-15 1944

Immediate cause of death: Pulmonary Tuberculosis

Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible] None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place or public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 7/15/44

G 16294 Corrected

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16294 Registered No.

82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 McCulloh St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days 11-4
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 McCulloh St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Lenora Savory

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 1, 1882

8. AGE: Years 62 | Months 2 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William H. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Addie Downs
15. Birthplace Md.

16 (a) Informant Mrs Mary Black
(b) Address 1006 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-44 (month, day, year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hensley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH April 16, '44 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12 1944, to Apr. 15 1944, and that I last saw h[er] alive on April 14 1944

Immediate cause of death: Cerebral hemorrhage — Duration: Few days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Garland Schmuff M.D.
Address 1804 E. Lan Ave. Date signed Jan 17.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 C

G 16295
Registered No.

Please answer all questions in full. Age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hunt Lanbad
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. yrs., mos., or days 3 6
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
a State Md b County
c City or town Baltimore
(If outside city or town limits, write (C.R.C.) and give town)
d Street No. 1019 Bennett Pl.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Hudson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 30 Months Days If less than one day hr. min

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm Smyth
13. Birthplace md.

MOTHER
14. Maiden Name Pauline Bier
15. Birthplace Md.

16 (a) Informant Hosp. record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mr Francis A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by registrar) (b) Huntington Williams M.E.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 16 1944 at 10 55 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3-9 1944 to 4-16 1944 and that I last saw h-r alive on 4-16 1944

Immediate cause of death Hemorrhage

Due to Rheumatic Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M.D.

Address Date signed

16296

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C 16296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1930 Wilkens Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 Wilkens ave
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Ella Harrison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ira [redacted] Harrison | 6 (c) If married, widowed, or divorced, give age: years

7. Birth date of deceased (mo., day, yr.): [redacted] 19, 1889

8. AGE: Years: 55 | Months: 2 | Days: 26 | If less than one day: hr. min

9. Birthplace: Balto. Md
(Town, county, and state)

10. Usual Occupation: W. W.

11. Industry or business

FATHER
12. Name: Benjamin D. Buck
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary A. Lyles
15. Birthplace: Md.

16 (a) Informant: Ira B. Harrison
(b) Address: 1930 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 18/44. (month) (day) (year)
(c) Cemetery or crematory: London Pk.
Location: 3801 Frederick Rd

18 (a) Funeral director: Harry H. Whitlock
(b) Address: 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar
APR 18 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 15 1944 19, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2/ 19[redacted] to 4/15 1944
and that I last saw her alive on 4/14 1944

Immediate cause of death: Bronchopneumonia — Duration: 4 days.

Due to: Myocardial degeneration C.V.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: James E. Bogrod M.D.
Address: 1905 W. Baltimore Date signed: 4/15/44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

C 16297.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

C 16297 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5101 Greenwich Avenue
(If rural give location)
(e) Citizen of foreign country? No Yes or No?
If yes, name country

3 (a) FULL NAME Elizabeth Day Reinle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mr August Reinle
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) January 25, 1870

8. AGE: Years: 74 | Months: 2 | Days: 21 | If less than one day: hr. min.

9. Birthplace: N.J.
(Town, county, and state)

10. Usual Occupation: H. W.

11. Industry or business

FATHER
12. Name: Charles F. Elmer
13. Birthplace: N. J.

MOTHER
14. Maiden Name: Mary Day
15. Birthplace: N. J.

16 (a) Informant: August Reinle
(b) Address: 5101 Greenwich Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Arnd Rigel
Location: Pikesville Md

18 (a) Funeral director: Harry H. Witzke
(b) Address: 401 Edmondson Ave

19 (a) APR 18 1944 (Date received by Registrar) Huntington Tittle, Registrar (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944, at 4.50 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from March 18 1944, to April 16 1944, and that I last saw her alive on April 16 1944.

Immediate cause of death: Respiratory & Cardiac Failure — Duration

Due to: Cerebral Embolus

Due to: Arteriosclerotic Heart Disease & Auricular Fibrillation

Other Conditions

(Include surgery within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: Wm. Edwin Day M. D.
Address: 1109 St. Paul Place Date signed: 4/20/44

VS 3

G 16298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121a

G 16298 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 Booth st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Booth st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Green

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5 1878

8. AGE: Years 66 | Months 2 | Days 30 | If less than one day hr. min.

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs. Margaret Hannan
(b) Address 1028 Booth st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 8 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md.

18 (a) Funeral director Gallagher & Jackson
(b) Address 946 Penna ave

19 APR 18 1944 (Date rec'd by registrar) Huntington Williams, Registrar

4-14-44 MEDICAL CERTIFICATION

20. DATE OF DEATH 1028 Booth 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1943 to Jan 1944 and that I last saw h alive on 19

Immediate cause of death — Duration

Due to Pulmonary Embolism

Due to Cardiac Failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Kalaeum M. D.

Address 1715 W Pratt Date signed 6/17/44

VS 180 For O.H.L. Procurator, by Howard J. Cassidy, M.D.

G 16299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 16299 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2239 E. Oliver st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 or 4

(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2239 E. Oliver st
(e) If foreign born, how long in U. S. A.? years ✓

3 (a) FULL NAME Emma G. Staylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22-1901

8. AGE: Years 42 | Months 9 | Days 2423 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER, FATHER

12. Name Vincent Staylor

13. Birthplace

14. Maiden Name Flora A Bright

15. Birthplace Baltimore

16 (a) Informant Flora Gough

(b) Address 2239 E. Oliver st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-44 (month), (day), (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville. Md

18 (a) Funeral director Henry Lutz

(b) Address 1203 N. Broadway

(c) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

APR 17

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 1944 at 10.02 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19 1943 to 4/15 1944 and that I last saw h alive on 4/15/44 19

Immediate cause of death: Bronchopneumonia — Duration: 6 days

Due to: Jacksonian epilepsy — 30 years

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Max Baum

Address 1501 N. Milton Ave Date signed 4/17/44

VS 3

G 16300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G 16300 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Huntingdon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilton B. Whisner.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1907

8. AGE: Years 36 | Months 7 | Days 12 | If less than one day: hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Clayton.

11. Industry or business

FATHER 12. Name Clarence L. Whisner.

FATHER 13. Birthplace Maryland.

MOTHER 14. Maiden Name Ida M. Whitmore

MOTHER 15. Birthplace Pennsylvania.

16 (a) Informant Ida M. Whisner.

(b) Address 2808 Huntingdon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20/44 (month) (day) (year)

(c) Cemetery or crematory Moreland Park.

Location Taylor Ave

18 (a) Funeral director Edmonds & Donovan

(b) Address 3615-17 Edmondson Ave

19 (a) (Date received by registrar) (b) Registrar

APR 18 1944 Huntington Williams, M.D.

VS 128

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1944 at 3 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10th 1943 to April 17 1944. and that I last saw ~~him~~ alive on April 17 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 yrs

Due to

Due to

Other Conditions Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Conrad Bode M. D.

Address 1920 Maryland Ave Date signed 4-18-44

16301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G 16301

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital-D-A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 544 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Rocset

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY HOSPITAL APR 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1944, at 2:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Myocardial Failure
Chronic Myocardial Degeneration
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Walter J. Lubinski M.D.
Medical Examiner.
Date signed 3/22/1944

0879

AB-86618 G 16302 *

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G 16302 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month-21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. Montgomery St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bettie Mae Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1925

8. AGE: Years 18 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Turner
13. Birthplace Va.

MOTHER
14. Maiden Name Hattie Nichols
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) (Date received by registrar) (b) Hunting Fox Williams, M.D. Registrar

APR 18 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944, at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27 1944. to 4/14 1944.
and that I last saw h~~e~~ alive on 4/14 1944.

Immediate cause of death
Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Paul O'Brien M. D.
Address B.C.H. Date signed 4/18/44

G 16303 Chisholm

G 16303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Leadenhall St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Gardner Chisholm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: James Chisholm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1919

8. AGE: Years 25 | Months 1 | Days 10 | If less than one day: hr min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Joe Gardner
13. Birthplace South Carolina

MOTHER
14. Maiden Name Emma ?
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Cy 2, Co. 1 Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery

19 ADR 18 1944 (b) Huntington Williams M.D.
Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1944, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1944 to April 17 1944, and that I last saw her alive on April 2 1944.

Immediate cause of death: Osteomyelitis of right hip — Duration: ??

Due to

Due to

Other Conditions Cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address Balt City Hosp Date signed 4/19/44

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G 16304 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33d & Calvert

(c) Hospital or institution: Union memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4904 Roland Ave #10 (If rural give location)

(e) Citizen of foreign country? YES (Yes or No)

If yes, name country FRANCE

3 (a) FULL NAME Mlle. Marthe Roux

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 25 July 1893

8. AGE: Years	Months	Days	If less than one day
50	8	22	hr. min.

9. Birthplace Lisieux, France (Town, county, and state)

10. Usual Occupation Teacher of French

11. Industry or business Language

FATHER

12. Name Dr. Pierre Roux

13. Birthplace France

MOTHER

14. Maiden Name Marthe Vinatier

15. Birthplace France

16 (a) Informant Mr. George E. Bennett

(b) Address 4904 Roland Avenue

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof Apr 19/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director John A. Mitchell Sons

(b) Address 1901 Eutaw Place

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

APR 18 1944

VS 12

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 April 1944 to 17 April 1944. and that I last saw h alive on 17 April 44

Immediate cause of death Cardiac Failure

Due to Generalized Carcinoma of Colon.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stephen J. Mumford M. D.

Address Union Mem. Hosp. Date signed 4-17-44

16305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 B

G 16305 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Blair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Viola Blair

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6th 1866

8. AGE: Years	Months	Days	If less than one day
77	10	11	hr. min.

9. Birthplace Galveston Texas (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business Laborer

FATHER
12. Name Henry Blair
13. Birthplace Texas

MOTHER
14. Maiden Name Unknown
15. Birthplace -

16 (a) Informant Mrs. Katherine Emsle
(b) Address 7 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook, Inc
(b) Address 127 St. Paul St

19 (a) APR 18 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944, at 10 ~~A~~ PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 14 1944, to Apr. 17 1944, and that I last saw him alive on Apr. 17 1944.

Immediate cause of death Lobar pneumonia — Duration

Due to Fractured hip

Due to Carcinoma of bone

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April 14, 1944 at 1 PM
(c) Where did injury occur? Baltimore (City or town) Maryland (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell in his home

23. Signature Paul A. Lubato M. D.
Address 213 Light St. Date signed Apr. 17, 1944

H.W. Wallenmeyer MD Asst Medical Examiner

C 16306

TO #87410

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C 16306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 Mangold St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grover White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eula White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1894

8. AGE: Years 50 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Davis Chemical Co.

FATHER
12. Name John White
13. Birthplace Virginia

MOTHER
14. Maiden Name Kate Southern
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location L. L. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 12?? St. Paul St

19 (a) APR 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1944 at 6:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1944 to 4/16 1944.
and that I last saw h[illegible] alive on 4/16 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Mattice M.D.
Address B.C.H. Date signed 4/18/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16307

BALTIMORE CITY HEALTH DEPARTMENT X G 16307

CERTIFICATE OF DEATH 131a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St

(c) Hospital or institution: Union Memorial Hosp. 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County

(c) City or town Albany (If outside city or town limits, write RURAL and give town)

(d) Street No. 135 Jay St. (If rural give location)

(e) Citizen of foreign country? O (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Frederick Gerald Deragon

3 (b) If veteran, name war I

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W-	

6 (b) Name of husband or wife Mrs. Alison Davis Deragon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1901

8. AGE: Years	Months	Days	If less than one day
43	2	14	15 hr. min.

9. Birthplace Vermont (Town, county, and state)

10. Usual Occupation Statistician

11. Industry or business

FATHER

12. Name Mr. Frederick Deragon (D)

13. Birthplace Vermont

MOTHER

14. Maiden Name Anna Fitzgerald (D)

15. Birthplace Vermont

16 (a) Informant Wife

(b) Address Same

17 (a) Removal (b) Date thereof 4/19/44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rensselaer

Location Rensselaer N.Y.

18 (a) Funeral director Fallon Funeral Home

(b) Address 217 Broad

19 (a) 4/18/44 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944. at 2.23 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1944 to 4-18 1944. and that I last saw him alive on 4-18 1944.

Immediate cause of death Cardio-Respiratory failure.

Duration

Due to Uremia

Due to Hypertensive Cardio-Vascular-Renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. W. Mann M.D. M. D.

Address J M N Date signed 4-19-44

16308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1321a

G 16308
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) !

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~317 Hopkins Rd~~, Rosedale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 Hopkins Road (near Trum
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Pearl Leonard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Thomas M Leonard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14th 1890

8. AGE: Years 47 | Months 8 | Days 3 | If less than one day hr. min

9. Birthplace Hopkinsville Ky
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name George W Heck
13. Birthplace Wisconsin

MOTHER
14. Maiden Name ?
15. Birthplace Wisconsin

16 (a) Informant Thomas M. Leonard
(b) Address 317 Hopkins Road.

17 (a) Burial (b) Date thereof 4, 19, 44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) APR 18 1944 (b) Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 19 44 to April 17 1944, and that I last saw her alive on April 17 19 44.

Immediate cause of death Uremia — Duration 1 week.

Due to Chronic Nephritis

Due to Hypertension

Other Conditions Pruritis Pernicious Anemia?
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Chronic Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Schaffle M. D.
Address Parkwood & Penn. Date signed 4/17/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G 16309 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1634 Westwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and the town)
(d) Street No. 1634 Westwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Rebecca Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife George M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1887

8. AGE: Years 56 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lloyd Parker
13. Birthplace md

MOTHER 14. Maiden Name Martha Banks
15. Birthplace md

16 (a) Informant Geo. M. Brooks
(b) Address 1634 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/44 (month) (day) (year)
(c) Cemetery or crematory Location Aberdeen, Md

18 (a) Funeral director Geo. S. Kelson
(b) Address 1393 Pressman St

19 APR 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1944 to 4/16 1944 and that I last saw h[illegible] alive on 4/16 1944.

Immediate cause of death Cardiac Hypertrophy

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Hatcher
Address 1715 Park Ave Date signed 4/17/44

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G 16310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1115D

G 16310
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 N. Longwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA MAY WOODS

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John T., Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1867

8. AGE: Years	Months	Days	If less than one day
76	8	5	hr min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Guard
13. Birthplace Canada

MOTHER
14. Maiden Name Mary Richter
15. Birthplace Germany

16 (a) Informant Mr. John T. Woods, Jr.
(b) Address Candlewick Rd., Stevenson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (Signature of Registrar) Washington Williams, M.D.

APR 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1944 at 6.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1942 to April 15 1944.
and that I last saw h alive on April 15 1944

Immediate cause of death Cardio Vascular Renal Failure — Duration 9 days

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Kirkbride M.D.
Address 921 Medical Arts Bldg Date signed 4/18/44

G 16311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16311 Registered No. 598

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Ridgewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Ridgewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE RACHEL McCUEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife James Watson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1859

8. AGE: Years	Months	Days	If less than one day
84	6	20	hr min.

9. Birthplace Princess Ann, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Beyly
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Wales
15. Birthplace Md.

16 (a) Informant Mrs. Alice Brown
(b) Address 3814 Ridgewood Ave.

17 (a) Burial (b) Date thereof 4/10/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

APR 18 1944
VS 10w

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 16, 1944, at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1941, to Apr. 16, 1944
and that I last saw her alive on 19

Immediate cause of death

Due to Chronic Arthritis

Due to Cardiac Asthenia

Duration 3 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 1340 S. Charles Date signed

G 16312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

G 16312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Vine St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Parker

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23 1908

8. AGE: Years	Months	Days	If less than one day hr.	min.
35	3	21		

9. Birthplace Baltimore, Md. (Town, County, and state)
10. Usual Occupation Store worker
11. Industry or business Store.

FATHER
12. Name Charles Parker
13. Birthplace Maryland.

MOTHER
14. Maiden Name Helen Barnes
15. Birthplace Maryland.

16 (a) Informant Albert Parker (brother)
(b) Address 255 N Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans, Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Undertaker or Embalmer) Huntington Williams, M.D. Address University Hospital Date signed 4-18-44

APR 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1944, at 1125 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1944, to April 14 1944, and that I last saw h[im] alive on April 14 1944.

Immediate cause of death Endocarditis and pulmonary edema — Duration

Due to Heart failure

Due to Pneumococcic endocarditis 60 days
Pneumonia

Other Conditions Meningitis (pneumococcic) + cystic aortitis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Pneu. endocarditis, cystic aortitis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. W. Tilt Jr. M. D.
Address University Hospital Date signed 4-18-44

CONTAGIOUS DISEASES (especially tuberculosis, typhoid, scarlet fever, diphtheria, puerperal fever, etc.) must be reported immediately by telephone to the Health Department. Please write plainly and legibly.

G 16313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G 16313

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 732 George St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 732 George St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Melvin Pinkney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/04

8. AGE: Years	Months	Days	If less than one day
40	-	9	hr. min.

9. Birthplace Eastern Shore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Jesse Pinkney

13. Birthplace Eastern Shore

MOTHER

14. Maiden Name Margaret Caldwell

15. Birthplace Eastern Shore

16 (a) Informant Nannie Caldwell

(b) Address sister

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location Sandy Spring - Md

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 327 N. Dalrymple Ave.

19 (a) (Date received by Registrar) APR 18 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15- 1944 at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1944 to 4/15 1944, and that I last saw him alive on 4/14 1944.

Immediate cause of death	Duration
Chronic Cardio Vascular Renal Disease	3 mos.
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. C. Jackson M. D.

Address Washington Date signed 4/17/44

VS 188

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 16314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 16314 Registered No.

PRESS WHITE PENCIL WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45-7-16
(e) Length of stay in Baltimore (yrs., mos., or days) 45-7-16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sister Hilda Hillman (Mary Callista)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1865

8. AGE: Years	Months	Days	If less than one day
78	5	7	hr. min.

9. Birthplace Ripon, Wisconsin (Town, county, and state)
10. Usual Occupation Religieuse
11. Industry or business

FATHER
12. Name Joseph Hillman
13. Birthplace Baden, Germany

MOTHER
14. Maiden Name Catherine M. Hoebrecht
15. Birthplace Albany, New York

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Hope
Location 6420 Reisterstown Rd.

18 (a) Funeral director Edward Memorial Co.
(b) Address 1424 Eutaw Place.

19 (a) APR 18 1944 (Date rec'd by registrar) (b) Registered by

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1944, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1934 to April 17 1944, and that I last saw h[illegible] alive on April 17 1944.

Immediate cause of death: Myocardial infarct — Duration: 2 days
Due to:
Due to:
Other Conditions: Marked Atheroma Sclerosis — 10 yrs
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dabney P. Shaw M. D.
Address 33 W. Madison St. Date signed

VS 2

C 16315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. C 16315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Whitridge (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sinclair Gosnell

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-2335

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Isabelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 27, 1901

8. AGE: Years 42 Months 3 Days 18 If less than one day hr. min.

9. Birthplace Granite, Maryland (Town, county, and state)

10. Usual Occupation Bar Man

11. Industry or business Elite Restaurant

FATHER
12. Name William Gosnell
13. Birthplace Maryland

MOTHER
14. Maiden Name Marie Bailey
15. Birthplace Maryland

16 (a) Informant Mrs. Isabelle Gosnell
(b) Address 429 Whitridge Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) APR 18 1944 (Registrar's Office) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1944 5.22 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma Throat

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B McNally M.D. Medical Examiner.
Date signed 4/17/44

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16316 Registered No.

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparks (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Nathaniel Jackson

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1936

8. AGE: Years 7 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Sparks, Md (Town, county, and state)

10. Usual Occupation –

11. Industry or business

FATHER
12. Name Thomas Jackson
13. Birthplace Sparks, Md

MOTHER
14. Maiden Name Pearl Jones
15. Birthplace Northumberland Va

16 (a) Informant Thomas Jackson
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-44 (month) (day) (year)
(c) Cemetery or crematory Gorsuch Cemetery
Location Cockeysville, Md

18 (a) Funeral director Landon M. Bixler
(b) Address Sparks, Md

19 (a) Huntingtown, Maryland

Date received APR 18 1944

VOID

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1944 at 12:40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-17-44 at 4 P. M.
(b) Where did injury occur? Work Rd - Sparks Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? no
(d) Means of injury struck by auto

23. Signature H L Wallenborn M.D.
Medical Examiner.

Date signed April 18, 1944

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

Reg. No. G-16317

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Glenarm Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Kathryn Depser (M. KATHRYN DEPSER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Depser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10th 1915

8. AGE: Years	Months	Days	If less than one day
28	9	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Howard L. Dodd
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ruppert
15. Birthplace Maryland

16 (a) Informant John Depser
(b) Address 4300 Glenarm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl. 21 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Groaden Funeral Home
(b) Address 7401 Belair Road

19 APR 18 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1944, at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 1944 to 4/18 1944, and that I last saw her alive on 4/18 1944.

Immediate cause of death	Duration
Tuberculous Meningitis	
Due to	
Due to	
Other Conditions Pregnancy of about 12 wks. duration. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Univ. Hospital Date signed 4/18/44

G 16318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16318 Registered No. 1706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4332 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM SACKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6. (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 79 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business

FATHER
12. Name Samuel David Sacks
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Samuel Sacks
(b) Address 4332 Reisterstown Rd.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof April 19/44 (month) (day) (year)

(c) Cemetery or crematory Brai Israel
Location Southern ave

18 (a) Funeral director Sol Levinson Bro
(b) Address 1124-26 W. North ave

19 APR 18 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944 at 3 20 A. M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/31/44 at 8:45 P. M.
(b) Where did injury occur? Dulaney & Mayfield Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by Lt. auto

23. Signature H. Z. Wollenweber M.D.
Medical Examiner.
Date signed 4/17/44

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Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16319

Registered No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (home 220 S. Schroeder St) Roscwood Training School (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee Handley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-9-30

8. AGE: Years 14 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state) school

10. Usual Occupation patient at Rosewood Training

11. Industry or business —

FATHER
12. Name David M. Handley
13. Birthplace Baltimore

MOTHER
14. Maiden Name Flora J. Schuler
15. Birthplace Baltimore

16 (a) Informant Robert Brooks
(b) Address 1338 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 18-44 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location West Balto st

18 (a) Funeral director Robt J Brooks
(b) Address 1338 Hollins st

(Date received by registrar) APR 18 1944 (By) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16 1944, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1944 to 4-16 1944 and that I last saw h~~e~~ alive on 4-16 1944.

Immediate cause of death: respiratory failure — Duration

Due to: meningococcal meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaye M. D.
Address Sydenham Hospital Date signed 4/18/44

G 16320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 16320

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Mercy Hospital 11W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 N. Eutaw Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Linzy Hise

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hessie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-10-1900

8. AGE: Years 43 | Months 9 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Linzy Hise
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mack Hise
(b) Address 1031 N Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 [illegible]

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

APR 18 1944

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 19 44 at 10:50 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

23. Signature Robert Lee Graham, M.D.
Medical Examiner.
Date signed April 15, 1944

For Robert Lee Graham, by Homer J. Buettner, M.D.

The age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16321 BALTIMORE CITY HEALTH DEPARTMENT G 16321

CERTIFICATE OF DEATH

Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland & 3302 Clifton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3302 Clifton (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice E. Flemming
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race Negro
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife H. P. Flemming
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 9 - 1885
8. AGE: Years 59 Months 5 Days 7 If less than one day hr. min.
9. Birthplace Long Green Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business
FATHER 12. Name Benjamin S. Proctor
13. Birthplace Md
MOTHER 14. Maiden Name Sarah E. Thompson
15. Birthplace Md
16 (a) Informant Husband
(b) Address 3302 Clifton Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Location Baltimore, Md
18 (a) Funeral director James T. Chase Home
(b) Address 638 E. Gilmor St
19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

APR 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17 1944. at 2:04 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from D.O.A. 19 , to 19 and that I last saw h alive on 19
Immediate cause of death Cerebral hemorrhage
Due to Malignant Hypertension
Due to Caused from Husband
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: Cerebral Hemorrhage

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Julius S. White M. D.
Address Provident Hospital Date signed 4-18-44

For O-H-L. Wallenmeyer, by Howard J. Weems, M.D.

G 16322

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16322 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Portugal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Szczeszek (SZCZESZEK)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1916

8. AGE: Years	Months	Days	If less than one day
13	4	22	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name John Szczeszek
13. Birthplace Balto

MOTHER
14. Maiden Name Stella Majewska
15. Birthplace Curtis Bay Md.

16 (a) Informant John Szczeszek
(b) Address 2011 Portugal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A A Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern ave

19 (a) 4 22 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944, at 7 a.m. P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hosp death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Yeatman M.D. Medical Examiner.
Date signed April 17 1944

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D G 16323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1443 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET E TAYLOR

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: JOHN H. TAYLOR

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JULY 3 - 1880

8. AGE: Years 68 | Months 9 | Days 14 | If less than one day: hr. min.

9. Birthplace: BALTO MD (Town, county, and state)

10. Usual Occupation: HOUSE WORK

11. Industry or business: AT HOME

FATHER
12. Name: GEORGE ESLIN
13. Birthplace: MARYLAND

MOTHER
14. Maiden Name: NOT KNOWN
15. Birthplace: MARYLAND

16 (a) Informant: THEODORE R TAYLOR
(b) Address: 1508 MARSHALL ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-2-44 (month) (day) (year)
(c) Cemetery or crematory: GLEN HAVEN CEM.
Location: GLEN BURNIE MD

18 (a) Funeral director: Bernard C Hirsh
(b) Address: 121 E Mount St

19 (a) (Date received by registrar) (b) Registrar

APR 18 1944

VS 151

Correct age is extremely important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 17 1944, at 8 45 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to hcy death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: H. L. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 4-18-44

G 16324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16324
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Beaumont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Joseph Sylvester May Sr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Sophia ~~Mary~~ Wells
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) 2/19/84
8. AGE: Years 60 | Months 1 | Days 27 | If less than one day: hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Automotive Parts

FATHER
12. Name Michael P. May
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Agnes ~~Mary~~ Benzinger
15. Birthplace Baltimore Md.

16 (a) Informant Mary E. May
(b) Address 511 Beaumont Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.
18 (a) Funeral director H. W. Mears and Son
(b) Address 505 N. Calvert St.
(c) (b)

APR 18 19 (Date received by registrar)
Huntington Williams, M.D. (Registrar)
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1944, at 12:25 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1944, to 4/16 1944, and that I last saw h im alive on 4/16 1944.

Immediate cause of death Staphylococcus endocarditis. — Duration —

Due to Staph. Septicemia

Due to Cerebral Embolism Subarachnoid Hemorrhage

Other Conditions Uremia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Multiple infarcts (all organs)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Univ. Hospital Date signed 4/16/44

46 1991
16325

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16325
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County HARFORD
City or town ROCKS
(If outside city or town limits, write RURAL and give town)
(c) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patsy Taylor
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-16-41
8. AGE: Years 2 | Months 7 | Days 1 | If less than one day: hr min
9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Elmer Taylor
13. Birthplace N.C.

MOTHER
14. Maiden Name Myrtle Church
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 20 44 (month) (day) (year)
(c) Cemetery or crematory DOUBLE SPRINGS
Location FURCHES BASH, CO. N.C.
18 (a) Funeral director Martin Spruill
(b) Address Jarrettsville Md
19 APR 18 1944 (b) (Date received by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 17 1944, at 9:00 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Apr 2 1944, to Apr 17 1944, and that I last saw her alive on Apr 17 1944.

Immediate cause of death: Respiratory failure — Duration: 1 hr
Due to: Brain Tumor — Duration: —
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul E. Wilson
Address Johns Hopkins Hosp. Date signed 4-18-44

G 16326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G 16326 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 Millmar St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Millmar St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy James Davis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife James Davis
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) Dec. 2, 1886
8. AGE: Years 57 | Months 4 | Days 14 | If less than one day: hr. min
9. Birthplace St Marys County (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Forrest
13. Birthplace St Marys County Md.

MOTHER
14. Maiden Name Lucie
15. Birthplace St. Marys County Md.

16 (a) Informant James Davis
(b) Address 1505 Millmar St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. County Md.
18 (a) Funeral director Mrs. Ralph J. Elliott
(b) Address 1129 N. Caroline St.
19 (a) [illegible] (b) Williams, Md. Registrar

APR 18 1944

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944, at 6:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1942 to April 16 1944.
and that I last saw h in alive on April 16 1944.

Immediate cause of death: Carcinoma uteri (Cervix) — Duration: 6 mos
Due to
Due to
Other Conditions Nephritis & Hypertension w Metastases Ovarian Pelvis
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ralph J. Young
Address 1129 E Monument Date signed 4/18/44

G 16327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 G 16327

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARROWS RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1814 Mullins St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1814 Mullins St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-8451

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Irene

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1912

8. AGE: Years	Months	Days	If less than one day: hr.	min
31	4	8		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER

12. Name Frank Johnson

13. Birthplace Md

MOTHER

14. Maiden Name Estella Willis

15. Birthplace Md.

16 (a) Informant Irene Johnson

(b) Address 1814 Mullins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19/44 (month) (day) (year)

(c) Cemetery or crematory St Stephens Cemetery

Location Middle River Md.

18 (a) Funeral director Mrs Robert A. Elliott & Dept

(b) Address 1129 N. Carolina St.

19 (a) (Date received by Registrar) APR 18 1944 (b) Huntington Williams, M.D. Registrar

VS 210

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15- 1944 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1944 to 4/15 1944, and that I last saw him alive on 4/14 1944

Immediate cause of death Hypertension

Conclusive by autopsy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

7 Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify) (type of place)

(e) Means of injury

23. Signature B. M. Hatcher

Address 1814 Mullins St Date signed 4/17/44

45246 G 16328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16328 / 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County CARROLL

City or town Sykesville (If outside city or town limits, write RURAL and give town)

Street No. FAIRHAVEN FARMS (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy HAWKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-44

8. AGE: Years	Months	Days	If less than one day
		6	hr min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Clarence HAWKINS

13. Birthplace N.C

MOTHER 14. Maiden Name Frances Willis

15. Birthplace N.C.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 20, 1944 (month) (day) (year)

(c) Cemetery or crematory Freedom Cemetery

Location Carroll Co., Md.

18 (a) Funeral director G. Harry Weers

(b) Address Lydonville, Md.

19 (a) Filed (b) Registrar Huntington Williams, M.D.

APR 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 18 1944, at 2.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 11 1944 to Apr 18 1944, and that I last saw HIM alive on Apr 18 1944.

Immediate cause of death Respiratory failure — Duration 6 days

due to Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul E. Wilson M. D.

Address Johns Hopkins Hosp. Date signed 4.18.44

G 16329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16329 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 S. Arlington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 S. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Fisher Vernon

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-1742

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Daisy Vernon

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 17, 1874

8. AGE: Years 70 | Months 1 | Days - | If less than one day: hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self

FATHER
12. Name John Vernon
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Lookingland
15. Birthplace Maryland

16 (a) Informant Mrs. Daisy Vernon
(b) Address 8 S. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19,1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 1005 W. Baltimore St.

APR 18 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944 at 9.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1944 to April 17 1944 and that I last saw him alive on April 16 1944.

Immediate cause of death Arteriosclerotic Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Seagrott M. D.

Address 1729 W. Lombard St. Date signed 4/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16330

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Monkton Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Marsh.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/6/1872

8. AGE: Years	Months	Days	If less than one day
72 yrs.	1	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Ann Naylor
15. Birthplace Maryland

16 (a) Informant Otho L. Marsh.
(b) Address 2625 Gillcrest Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21, 44 (month) (day) (year)
(c) Cemetery or crematory St Joseph's
Location Texas Md.

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks

APR 19 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944, at 5 22/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6th 1944. to April 18 1944. and that I last saw him alive on April 18 1944.

	Duration
Immediate cause of death: Cardiac failure	48 hrs.
Due to Arteriosclerotic heart disease	20 yrs.
Due to Chronic Nephritis	20 yrs.
Other Conditions Uremia.	2 weeks

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Z. Berry M.D.
Address Mercy Hospital Date signed 7/18/44

VS 150

C 16331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. C 16331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3710 Dudley ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Dudley ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Feuchter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Elizabeth Feuchter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5 - 1880

8. AGE: Years	Months	Days	If less than one day
64	1	12	hr. min

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business U S Custom House

FATHER
12. Name Charles Feuchter
13. Birthplace Balto

MOTHER
14. Maiden Name Catharine Larkin
15. Birthplace England

16 (a) Informant Elizabeth Feuchter
(b) Address 3710 Dudley Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20/44 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (Signature and title) APR 19 1944 Huntington Williams MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1939 to April 17 1944. and that I last saw him alive on April 11 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 5 Years

Due to Hypertension Cardio Vascular Renal Disease — Duration 5 years

Due to Arteriosclerosis & Age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerry S Bagley M.D.
Chesapeake Av & Bellona Date signed 4/19/44

G 16332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 B

Registered No. G 16332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph H Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1886

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	9	3		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mamie V. Johnson
(b) Address 1523 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County, Md.

18 (a) Funeral director Mrs. Robert G. Elliott Dept.
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944, at M

21. I certify that death occurred on the date above stated, that I attended deceased from April 13 1944 to April 15 1944, and that I last saw alive on April 14 1944.

Immediate cause of death: Carcinoma of Tongue — Duration: 1 yr.
Due to Carcinoma of mouth
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation April 14 1944
Major findings of operation: Epithelioma of Mouth & Tongue
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 1207 N. Carlin Date signed April 18 1944

Harris

VS 180
APR 10 1944

G 16333 Tran

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16333 Registered No. 90 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hospital Women of Md
(c) Hospital or institution: Lafayette & John St 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 99da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Lyndhurst Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS FRANCES HELEN BOUDREAU

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	divorced & Remarried

6 (b) Name of husband or wife HERMAN Joseph Boudreau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 29, 1909

8. AGE: Years	Months	Days	If less than one day
34	8	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Telephone Supervisor
11. Industry or business
12. FATHER Name James Cooberry
13. Birthplace
14. MOTHER Maiden Name Margaret Wright
15. Birthplace Maryland
16 (a) Informant Lt. Herman J. Geo Boudreau
(b) Address 812 Lyndhurst St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location 4301 Frederick Rd
18 (a) Funeral director Harry A. Wirth
(b) Address 4101 Edmondson Ave
19 (a) APR 19 1944 (Date received by local registrar) (b) Huntington Williams Mem. Hospital for Women Md

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 17 1944, at 9.22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 10 19 44 to April 17 19 44 and that I last saw h CR alive on APRIL 17 19 44.

Immediate cause of death	Duration
Cardio - Respiratory Failure	
Due to Acute Adhesive Pericarditis	
Due to Pulmonary Fibrosis, Mediastinitis	
Other Conditions Chronic and acute Congestive Congestion	

(Include pregnancy within 3 months of death)
Date of operation March 29, 1944.
Major findings of operation: Pulmonary Adhesions + Fibrosis - Bilateral
of autopsy: Acute adhesive Pericarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no if place)
(e) Means of injury

23. Signature Harland Elwood Day M. D.
Address Hospital for Women Md Date signed 4/17/44

VS 3

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16334 (struck) G 16334 Registered No.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1933 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Mayola

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	widower

6 (b) Name of husband or wife late Ellen Jane Staggs 6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1889

8. AGE: Years	Months	Days	If less than one day
54	3	17	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business Retired

FATHER
12. Name — Mayola
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mrs Walter
(b) Address 3123 Sollers Point Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 E Monument Ave Huntington Williamsport, Md.

19 (a) (b) Registrar

APR 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17- 1944, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1944 to 4-17 1944, and that I last saw him alive on 4-16 1944.

Immediate cause of death: Coronary thrombosis — Duration: 3 days
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Morris Schreiber
Address 54 S. Fulton Ave Date signed 4-18-44 M. D.

G 16335   BALTIMORE CITY HEALTH DEPARTMENT   G 16335

CERTIFICATE OF DEATH 49a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Streets
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Brighton Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Mary HOFFMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank S. Hoffman
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) December 31, 1869

8. AGE: Years	Months	Days	If less than one day
74	3	14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Nicolas Smith
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Theresa Anna Albright
15. Birthplace Westminster, Maryland

16 (a) Informant Frank S. Hoffman, husband
(b) Address 2807 Brighton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Off Frederick Rd

18 (a) Funeral director Harry W. Witzke
(b) Address 4101 Edmondson Ave

19 (a) APR 19 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1944 to April 15 1944 and that I last saw her alive on April 15 1944.

Immediate cause of death	Duration
Hypostatic pneumonia	24 hours
Due to Exploratory laparotomy	
Due to Generalized abdominal carcinomatosis	2 weeks? even
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 14, 1944
Major findings of operation: Generalized abdominal carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, etc.)
(e) Means of injury

23. Signature Women's Hospital, Balto. M. D.
Address James R. McCord Date signed 4/15/44

VS 2

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 16336 | BALTIMORE CITY HEALTH DEPARTMENT | C 16336
Registered No.

CERTIFICATE OF DEATH 94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 S. Callender St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 S. Callender (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mamie Ledley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Daniel Ledley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 26-1887

8. AGE: Years	Months	Days	If less than one day
56 ~~57~~	11	19	hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Jacob Laster
13. Birthplace Germany

MOTHER
14. Maiden Name Rose Nuckand
15. Birthplace —

16 (a) Informant Daniel Ledley
(b) Address 1045 Callender

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director Harry Metzke
(b) Address 4196 Edmondson Ave

19 (a) APR 19 1944 (Date rec'd by registrar) (b) Huntington Williamsville, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15/44 19 , at 8.00 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection, or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~natural~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 4/17/44

(over)

G 16337

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G 16337
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 E West St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Friedman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 64 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House work

FATHER
12. Name Morris Merowitz
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel ?
15. Birthplace Russia

16 (a) Informant Nathan Friedman
(b) Address 301 E West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150 APR 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944 at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to March 18 1944, and that I last saw h[illegible] alive on 4/10 1944.

Immediate cause of death: Heart failure

Due to: Ca of Breast

Due to: metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1941

Major findings of operation: Ca of Breast

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel R. Friedman M. D.
Address Sinai Hosp.
Date signed 4/11/1944

G 16338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16338 No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument St & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4323 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Rockin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Betty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 24, 1900

8. AGE: Years 43 | Months 3 | Days 25 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Schauffer Taxi Cab

FATHER
12. Name Solomon Rockind
13. Birthplace Russia

MOTHER
14. Maiden Name Helen Cohen
15. Birthplace Russia

16 (a) Informant Betty Rockin
(b) Address 4323 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19, (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 N. North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 160 APR 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944, at 6.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1944, to April 18 1944, and that I last saw him alive on 6.20 P.M. 1944.

Immediate cause of death: Cardio respiratory failure — Duration

Due to Pneumonia — Duration over

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 7 - 1944

Major findings of operation: Lung abscess

of autopsy: Diagnostic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1944 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel R. Rosen, M. D.
Address Sinai Hospital Date signed 4/19/44

PINAS

G 16339 ✓ G 16339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 E. 34th. St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5345 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Louise Wirth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Noah E. Kirk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1860

8. AGE: Years 84 | Months 1 | Days 26 | If less than one day hr min.

9. Birthplace Balto., Co., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Wesley Jones
13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Towery
15. Birthplace Md.

16 (a) Informant Mr. Charles Kirk
(b) Address 4121 Newbern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) (b) Registrar

APR 19 1944

Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1944, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1944, to 4/17 1944, and that I last saw her alive on 4/14 1944.

Immediate cause of death Cerebral Hemorrhage & resulting paralysis

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Tunnell
Address 3902 Groveland Ct Date signed 4/18/44

15

G 16340 ✓ G 16340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Prout Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME FANNIE M. BATEMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. T. Bateman
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1903

8. AGE: Years	Months	Days	If less than one day
40	5	3	hr ..... min.

9. Birthplace Ohio
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Anthony Ferry
13. Birthplace Ohio
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Capt. Wm. T. Bateman
(b) Address 400 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ..... (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)
APR 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1944, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to April 17 1944, and that I last saw her alive on April 12 1944.

Immediate cause of death Coronary Occlusion — Duration 1 1/2 yrs

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature J M Collins M. D.
Address 332 Frederick Ave Date signed 4-19-44

G 16341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 16341 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1419 Argyle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Rock Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Captain William Henry Smith
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C	M

6 (b) Name of husband or wife Lillian Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/21/1870

8. AGE: Years	Months	Days	If less than one day
74		26	hr. min.

9. Birthplace Leonardtown Md.
(Town, county, and state)
10. Usual Occupation Fisherman.
11. Industry or business

FATHER
12. Name Robert Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Swett
15. Birthplace Va.

16 (a) Informant Mrs Lillian L Smith
(b) Address 1419 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)
(c) Cemetery or crematory Rock Hall Cem.
Location Rock Hall, Md.

18 (a) Funeral director Charles R. Law
(b) Address 102 Md. Ave.

APR 19 1944 Livingston Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17- 1944 at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1943 to 4-17 1944 and that I last saw h[illegible] alive on 4-17 1944

Immediate cause of death Cardiac failure

Due to Myocarditis

Due to Arteriosclerosis

Other Conditions syphilis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis E. Hamm M.D.
Address 2240 Woodbine Ave Date signed 4-18-44

G 16342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G 16342

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 755 Dover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 755 Dover St
(If rural give location)
(e) Citizen of foreign country? Colored (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	col	Widower

6 (b) Name of husband or wife Mary K. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July - 1868.

8. AGE: Years	Months	Days	If less than one day
75	9		hr. min.

9. Birthplace Charlestown and
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name George Wesley Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Harriett.
15. Birthplace Maryland

16 (a) Informant Hyman Brody - Son
(b) Address 755 Dover St.

17 (a) Burial (b) Date thereof April 20 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

APR 19 1944 (Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944 at 5 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to April 19 44; and that I last saw h-e alive on April 19 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension Cardio Vascular Renal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Evelyn M. D.
Address 805 [illegible] Date signed

VS 180

G 16343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47D

Registered No. G 16343

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N
(b) Street address 808 Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanora Addison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10, 1871

8. AGE: Years	Months	Days	If less than one day
73	- 3	- 5	hr. min.

9. Birthplace Somerset Co Md
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business "

FATHER
12. Name Henry Wise
13. Birthplace Somerset Co Md

MOTHER
14. Maiden Name Mary Pratt
15. Birthplace Richmond Va.

16 (a) Informant Chas H. Addison (Son)
(b) Address 610 Gold St

17 (a) Burial (b) Date thereof April 19, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St
(c) Huntington for Williams, Mgr.
(Signature of registrar) Registrar

APR 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944 at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 43 to April 15 19 44, and that I last saw h alive on April 10 19 44.

Immediate cause of death Carcinoma Lung

Duration 9 mos

Due to

Due to

Other Conditions Abscess of Lung

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ralph J Young
Address 1424 E Monument Date signed 4/18/44

VS 150

G 16344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G 16344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N Bradford St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 N Bradford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Minnie Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1st 1874

8. AGE: Years 69 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Confectionery Business

11. Industry or business

FATHER
12. Name Jost Smith
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs Minnie Smith
(b) Address 1701 N Bradford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19th 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Leo G. Cook
(b) Address 1403 N Patterson Park ave

APR 19 1944
(Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16th 1944, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12, 1942, to April 16 1944, and that I last saw him alive on April 16 1944.

Immediate cause of death	Duration
Chronic Myocarditis	5 years?
Due to Hypertension	5 years?
Due to Arteriosclerosis	5 years?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Dorsch M. D.
Address 530 E. Baltimore St. Date signed 4/17/44

VS 3

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G 16345 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Lambert Rd. Lambeth (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Joseph P. Kennedy
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of ~~husband or~~ wife Elizabeth V. Stirling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1886

8. AGE: Years 55 | Months 10 | Days 16 | If less than one day hr min. 15

9. Birthplace Phila. Penn. (Town, county, and state)
10. Usual Occupation Business Man
11. Industry or business Foundry

FATHER
12. Name Patrick Kennedy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Lynn
15. Birthplace Phila. Penn.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.
18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.
(c) Huntington Williams M.D. Registrar

APR 19 1944 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1944 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1944 to 4/17 1944 and that I did not see him alive on 4/17 1944

Immediate cause of death Acute Uremia
Hemorrhage — Duration 6 hrs.
Due to Portal Cirrhosis — Duration 3 mos.
Due to Chronic Alcoholism
Other Conditions Avitaminosis - Hypertension C.V. Disease
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —
23. Signature T. B. McFadden M. D.
Address Mercy Hospital Date signed 4/12/44

VS 180

G 16346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

G 16346
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 417 W. Mulberry St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Frank Rada

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1890

8. AGE: Years	Months	Days	If less than one day
53	8	28	17 hr. 25 min.

9. Birthplace Cleveland, Ohio (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

MOTHER | FATHER

12. Name John James Rada

13. Birthplace Bohemia

14. Maiden Name Anna

15. Birthplace Bohemia

16 (a) Informant Deceased.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son

(b) Address 805 N. Calvert St.

APR 19 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944 at 5:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to April 16 1944 and that I last saw HIM alive on April 16 1944.

Immediate cause of death Respiratory failure. — Duration 15 min.

Due to Uremia convulsions. — 2 days

Due to Nephritis. — 3 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul R. Ziegler M. D.

Address Mercy Hosp. Date signed 4-16-44

G 16347 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 92a G 16347

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 873 Linden ave St., 13 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Luvenia Gaither

If U. S. Veteran specify WAR

(a) Residence: No. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	Colored	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Even Gaither

6. DATE OF BIRTH (month, day, year) 3/4/877

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. House Work

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) near Mt. Airy Carroll Co. Md

FATHER

13. NAME John Anderson

14. BIRTHPLACE (city or town) (State or country) Carroll co, md

MOTHER

15. MAIDEN NAME Amanda Bines

16. BIRTHPLACE (city or town) (State or country) Carroll Co. Md

17. INFORMANT Cardine Fisher
(Address) 873 Linden ave

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Zion Cem. Date April 22 1944

19. UNDERTAKER F. M. Snyder
(Address) Mt. Airy Md

20. Filed APR 19 1944 19 Huberta M. Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 15, 19 44

22. I HEREBY CERTIFY, That I attended deceased from April 3, 19 44 to April 15 19 44

I last saw her alive on April 12, 19 44 Death is said to have occurred on the date stated above, at 11 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Insufficiency	April

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) H. C. Pettet M. D.

(Address) 817 Hamilton Ave

V. S. 3

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 16348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16348

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2047 Flint St (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Antoinette Oppel

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB. 23 1944

8. AGE: Years | Months: 1½ | Days: 24 | If less than one day: hr. ..... min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business .....

FATHER

12. Name EARL OPPEL

13. Birthplace BALTO. MD.

MOTHER

14. Maiden Name JURINA LUCAS

15. Birthplace BALTO. MD.

16 (a) Informant JURINA OPPEL (MOTHER)

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 19/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD.

18 (a) Funeral director Lilly and Zeiler Inc.

(b) Address 403 S. WOLFE ST.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 1944 to 4/17 1944, and that I last saw her alive on 4/17 1944.

Immediate cause of death: Respiratory Failure

Due to Pneumonia

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

Signature Elizabeth Conrad M. D.

Address Johns Hopkins Hosp. Date signed 4/19/44

G 16349 ✓ G 16349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 W 39 st st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME HARRIET - PFEIFFER - BURGER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 25 - 1870

8. AGE: Years 72 | Months 3 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Geo Pfiffer
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Edna Spurrier
(b) Address 3209 Hilltop Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Rd

18 (a) Funeral director Edward Loudon
(b) Address 2219 Harford Blvd.

APR 19 1944

19 (a) ..... (Date rec'd by registrar) (b) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1944, at 12.35 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to Arteriosclerosis

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 4-18-44

VS 151

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 46350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5628 Laurelton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5628 Laurelton Ave (If rural give location)
(e) Citizen of foreign country? Laurelton Yes or No
If yes, name country

3 (a) FULL NAME John Robert Moore Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha A.
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Nov. 6 1889

8. AGE: Years	Months	Days	If less than one day
54	5	11	hr. min

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Barber - Owner
11. Industry or business

FATHER
12. Name William T Moore
13. Birthplace Md

MOTHER
14. Maiden Name Rose Ann Mc Kenna
15. Birthplace Md

16 (a) Informant Mrs Martha A. Moore, Sr.
(b) Address 5628 Laurelton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 20-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

APR 19 1944 (b) Huntington Williams, M.D.

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944, at 8.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 19 43 to April 19 1944 and that I last saw h in alive on April 19 1944

Immediate cause of death: Chronic myocarditis — Duration 1 yr
Due to: Chronic hypertensive arteriosclerosis — 1 yr
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Solomon M.D.
Address 6217 Harford Rd Date signed 4/19/44

G 16351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G 16351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Broadway • Fairmont

(c) Hospital or institution:

Church Home • Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days 6

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 5

(d) Street No. 7414 Park Drive (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME John R. Kopp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Katherine Kopp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-6-1879

8. AGE: Years	Months	Days	If less than one day
44 46	4	12	hr min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Plant engineer

11. Industry or business

FATHER

12. Name Michael Kopp

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name (Unkn.)

15. Birthplace Baltimore, Md.

16 (a) Informant Wife-Katherine H. Kopp

(b) Address 7414 Park Drive ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor ave. - Parkwood

18 (a) Funeral director Leonard J. Rucks

(b) Address 5305 Harford Rd.

(c) APR 19 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18 - 1944, at 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9 1944 to 4-18 1944, and that I last saw him alive on 4-18 1944.

Immediate cause of death Subarachnoid Hemorrhage — Duration 12 days.

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address Church Home & Hospital Date signed 4/20/44 M. D.

VR 150

G 16352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183

G 16352
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 East Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Presbury St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Corp. Marion E. Gore

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10, 1922

8. AGE: Years: 21 | Months: 9 | Days: 6 | If less than one day: hr min

9. Birthplace: Carroll Co Maryland (Town, county, and state)

10. Usual Occupation: Mechanic

11. Industry or business:

FATHER
12. Name: Frederick E. Gore
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Alverta Powder
15. Birthplace: Maryland

16 (a) Informant: Mr. Frederick E. Gore
(b) Address: R.D. Sykesville. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-44 (month) (day)
(c) Cemetery ~~or crematory~~ Calvary
Location: Eldersburg, Carroll Co. Md.

18 (a) Funeral director: G. H. Wells
(b) Address: Huntingtown, Md.

19 (a) APR 19 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944, at 6 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [x], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury Unknown at 4/1 M.
(b) Where did injury occur? Harbor (found foot of Bay St)
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury Drowning

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed April 17, 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G 16353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16353
Registered No.

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3721 HUDSON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days 35 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits write RURAL and give town)
(d) Street No. 3721 HUDSON ST.
(If rural give location)
(e) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME JOHN MERZBACHER
3 (b) If veteran, name war NO
3 (c) Social Security Account No.
4. Sex MALE
5. Color or race WHITE
6 (a) Single, married, widowed, or divorced WIDOWER
6 (b) Name of husband or wife ANNA MERZBACHER
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr DEC. 28 1882
8. AGE: Years 61 Months 3 Days 20 If less than one day hr min
9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation BREW MASTER
11. Industry or business FREE STATE BREWERY

FATHER
12. Name UNKNOWN
13. Birthplace GER.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GER.

16 (a) Informant DAUGHTER
16 (b) Address 3721 HUDSON ST.
17 (a) BURIAL (Burial, cremation, or removal)
17 (b) Date thereof APR. 20/44 (month) (day) (year)
17 (c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD
18 (a) Funeral director Lilly and Geiler Inc.
18 (b) Address 407 E. WOLFE ST.
19 (a) Date received by registrar APR 19 1944 (b) Registrar Huntington Williams, M.D.

VS 150

For Md. Hollerith Co., by Towers & Emerick, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 17 1944 at 8/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to April 17 1944
and that I last saw him alive on April 17 1944.

I hereby fix the cause of death:

Duration
10 days

Hypostatic Pneumonia
failing circulation
Due to restriction in bed
as result of fracture
Surgical neck of right
humerus and acromial end
of clavicle
Chronic poly neuritis with
Deformity due to
contractures -

right clavicle

PHYSICIAN
Underline the cause to which death should be charged statistically

Operation:
Date of operation:
Major findings of operation:
Date of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence March 19 1944 at 1 P.M.
(c) Where did injury occur? 3721 Hudson St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home Farm Industrial Public While at work? Specify
(e) Means of injury

23. Signature Hollis J. Schendler M.D.
Address 3508 Bank St Date signed 4/18/44

G 16354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16354
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 N Pulaski St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
a. State Md County
c. City or town Baltimore
(If outside city or town limits write RURAL and give town)
d. Street No. 1705 N Pulaski St
(If rural give location)
e. Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida J Aftersteir

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 1880

8. AGE: Years 64 Months Days If less than one day hr min

9. Birthplace Russia (Town, county, and state or foreign country)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Louis Levinson
13. Birthplace Russia
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Harry Afterstein
(b) Address 1705 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-44 (month) (day) (year)
(c) Cemetery or crematory B'nai Israel Cong.
Location Southern Avenue

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) [illegible] (b) Registrar Huntington Williams M.D.

APR 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19 1944 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1942 to 4/18 1944 and that I last saw h/er alive on 4/17/44 1944

Immediate cause of death: Coronary Occlusion — Duration 2 yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
c. Where did injury occur?
(City or town) (County) (State)
d. Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
e. Means of injury

23. Signature Maurice Chaderow M. D.
Address 2225 Linden Date signed

C 16355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 16355 Registered No.

482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Oakley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fay Cutler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Albert Cutler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1916

8. AGE: Years 34 | Months | Days | If less than one day: hr | min

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Rubow
13. Birthplace Russia

MOTHER
14. Maiden Name Addie —
15. Birthplace Russia

16 (a) Informant Albert Cutler
(b) Address 2600 Oakley Ave 4-19-44

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 4-19-44
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Peiros Inc
(b) Address 1439 E. Balto St

19 APR 19 1944 (Date received by registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4:45 P.M. 4/18 19 44, at 4:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from April 16 1944, to April 18 1944, and that I last saw h[illegible] alive on April 17 1944

Immediate cause of death: cardio respiratory failure — Duration

Due to: pneumonia

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 19[illegible]

Major findings of operation: [illegible]

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(Specify type of place)
(e) Means of injury

23. Signature Samuel R. Rosen

Address Sinai Hospital Date signed 4/19/44

G 16356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16356

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1327 N. Carey (If rural give location)

(e) Citizen of foreign country? ~~(Yes or No)~~ If yes, name country

3 (a) FULL NAME Charles Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1912

8. AGE: Years 31 | Months 6 | Days 25 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Waiter

11. Industry or business

FATHER

12. Name: Dewitt C. Carter

13. Birthplace: Annapolis, Md.

MOTHER

14. Maiden Name: Edith Stall

15. Birthplace: Baltimore, Md.

16 (a) Informant: Ruth Williams

(b) Address: 906 E. Montgomery St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20, 1944 (month) (day) (year)

(c) Cemetery or crematory: Arbutus Mem. Park.

Location: Balto. Co. Md.

18 (a) Funeral director: Mr. Lunge N. Holland

(b) Address: 1631 Druid Hill Ave.

19 (Signature of local registrar): Ruth Williams

APR 19 1944

VS 150

MEDICAL CERTIFICATION

45

20. DATE OF DEATH April 16 1944 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1944, to April 16 1944, and that I last saw him alive on April 16 1944.

Immediate cause of death: Diabetic Coma — Duration

Due to: Diabetic Acidosis

Due to (or as a result of): Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Jeff Bamfield

Address: Provident Hospital Date signed: 4/22/44

G 16357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 6

G 16357
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Division St. Balt. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Hax.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr ?
8. AGE: Years 55 | Months | Days | If less than one day: hr min
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

MOTHER / FATHER
12. Name George W. Hax.
13. Birthplace Maryland
14. Maiden Name Alice Rogs
15. Birthplace Maryland.

16 (a) Informant Peter H. Hax.
(b) Address 12 11 Smithson St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) April 18, 1944
(c) Cemetery or crematory Mt. Lucas Cem.
Location Baltimore Co. Md.
18 (a) Funeral director Mrs. Lou. H. Holland
(b) Address 1631 Druid Hill Ave.
19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS JN
APR 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944, at 12 33 A M
21. I certify that death occurred on the date above stated, that I attended deceased from April 15 1944 to April 18 1944 and that I last saw him/her alive on April 18 1944

Immediate cause of death Respiratory Failure. — Duration 5 min.
Due to Meningococcic Meningitis. — 3 days.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury
23. Signature Paul R. Ziegler
Address Mercy Hosp. Date signed 4-18-44 M D

G 16358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16358

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 683 N. Carey St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Violet Neal

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1906

8. AGE: Years 37 | Months 11 | Days 9 | If less than one day: hr. min

9. Birthplace Shippingsburg, Pa. (town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Thomas L. Pedigrew
13. Birthplace Lexington, Va.

MOTHER
14. Maiden Name Minnie
15. Birthplace Shippingsburg, Pa

16 (a) Informant Mrs. Wm. A. Neal
(b) Address 633 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Hall
(b) Address 1681 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1944, at 4 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 16 1944 to April 16 1944 and that I last saw her alive on April 16 1944.

Immediate cause of death: Hypertensive Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Bangiere

Address Provident Hospital Date signed April 19 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

File No. 16359 — 108 — G 16359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Division st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-3083

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1893

8. AGE: Years	Months	Days	If less than one day
50	9	10	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George W. Jefferson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jennings
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemty
Location a a co.

18 (a) Funeral director Robert E. Jennings
(b) Address 1501 madison ave

19 (a) APR 19 1944 (Registrar's date) Registrar
Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1944 at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1944 to 4/17 1944 and that I last saw him alive on 4/17 1944.

Immediate cause of death: Lobar pneumonia — Duration: 7 /

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. L. Sergmon M.D.
Address BCH Date signed 4/18

G 16360 G 16360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4409 Roland Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 8 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Va (b) County Clarke

(c) City or town Berryville, Va.
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lavenworth Riddle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed or divorced Widowed

6 (b) Name of husband or wife James Riddle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1870

8. AGE: Years 74 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Shreveport La.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Frederick Peabody Lavenworth

13. Birthplace Charlotte, N.C.

MOTHER

14. Maiden Name Eliza C. Lawrence

15. Birthplace Shreveport La.

16 (a) Informant Hester L. Joslin

(b) Address 4400 Roland Ave

17 (a) Removal (b) Date thereof Apr 20 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Old Blandford

Location Petersburg, Va

18 (a) Funeral director Henry W. Jenkins & Sons Co

(b) Address 22 Sheild & Orchard Sts

APR 19 1944

(a) Date rec'd by registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1944 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to 4-18 1944 and that I last saw h. alive on 4-16 1944

Immediate cause of death Cancer

Duration 4 years

Due to

Due to over

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature C. Irving Joslin M.D.

Address 11 E. Chase St Date signed 4/19/44

Huntington Williams, M.D.

G 16361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

G 16361 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Ave.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1806 Mc Henry St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Henry Marriott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Agnes M. Marriott.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10-1869

8. AGE: Years 74 | Months 6 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Trucker

11. Industry or business Light Farming

FATHER 12. Name William H. Marriott

13. Birthplace Baltimore Co. Md.

MOTHER 14. Maiden Name Marcella Smith

15. Birthplace Baltimore Co. Md.

16 (a) Informant Mrs. Agnes M. Marriott

(b) Address 1806 Mc. Henry St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof April 20/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olive Cemetery

Location Randallstown, Md.

18 (a) Funeral director Charles J. Seguab

(b) Address 505 N. Monroe St.

19 (a) (b) Huntington Williams, M.D.

APR 19 1944 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17 1944, at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1944 to 4-17 1944.

and that I last saw h/ alive on 4-17 1944.

Immediate cause of death: Post operative shock

Due to: Abdominal Laparotomy for Carcinoma of Stomach

Due to: (Gastric Intestotomy was done)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-17-44

Major findings of operation: Inoperable Carcinoma of Stomach

of autopsy: none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard W Attix

Address St Agnes Hospital Date signed 4/17/44

3

G 16382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G 16382 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Light St.
(c) Hospital or institution: South Balto Gen'l Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Hanbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores M. BECKNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14, 1925

8. AGE: Years	Months	Days	If less than one day
19	1	3	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business

FATHER
12. Name Wm. P.
13. Birthplace Md.

MOTHER
14. Maiden Name Florence E. Hood
15. Birthplace Va.

16 (a) Informant Family
(b) Address 1107 Hanbert St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 4-20-44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Rutherford Highway

18 (a) Funeral director James J. McCully
(b) Address 306 E. Lost Ave.

19 (a) (Date rec'd by registrar) APR 19 1944 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1944 to 4/17 1944, and that I last saw her alive on 4/17 1944.

Immediate cause of death: Tuberculosis Pulmonal
Due to Endocarditis
Due to Strep. viridans
Due to Rheumatic heart disease

Duration
3 1/4 mo.
12 y.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles D. MacDonald M. D.
Address 1713 Light St. Date signed 4-17-44

G 16363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944

G 16363 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice C. Tucker.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Chas H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1867

8. AGE: Years 76 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name —

13. Birthplace —

MOTHER 14. Maiden Name Mary Reynolds.

15. Birthplace Md.

16 (a) Informant Family

(b) Address 2021 W. North Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 4-01-44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Pikesville Highway

18 (a) Funeral director James L. McElroy

(b) Address 130 E. Lanvale.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsville, Md.

APR 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1944 10-45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5/44 19 to 4/7/44 and that I last saw h— alive on 4/7/44

Immediate cause of death Coronary Thrombosis

Due to Arterio-Sclerosis

(Secondary)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 7 days approx. 5 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H C Hansen M.D.

Address 1924 Mount Royal Ave (Physician)

G 16264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1937 G 16264

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1930 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1866

8. AGE: Years	Months	Days	If less than one day
78	0	16	hr min

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name John W. Barnes
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Barnes
15. Birthplace Md.

16 (a) Informant B. C. H Records
(b) Address 4940 Eastern Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 4-20-37 (month) (day) (year)
(c) Cemetery or crematory Mt. Kendrick Bros
Location Finksburg, Md

18 (a) Funeral director James L. McCauley
(b) Address 1806 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Wilkerville, Md

APR 7 W 1937

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17 1937 at 3.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1937 to 4-17 1937. and that I last saw h alive on 4-17 1937.

Immediate cause of death: Cardiac failure

Due to: Arterio Sclerosis Heart disease

Due to:

Other Conditions (Include pregnancy within 3 months of death)

Duration: 2

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Matthews M.D.
Address B. C. H Date signed 4-18-37

G 16365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 61

G 16365 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 W. CROSS St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 W. CROSS ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA L. STANSBURY

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife CHARLES M.

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) MARCH 15 1894

8. AGE: Years 50 | Months 1 | Days 2 | If less than one day hr min

9. Birthplace md (Town, county, and state)

10. Usual Occupation H. WIFE

11. Industry or business

FATHER 12. Name DAVID HOWELL

13. Birthplace md

MOTHER 14. Maiden Name MARGARET KNODE

15. Birthplace md

16 (a) Informant CHARLES M. STANSBURY

(b) Address 605 W. CROSS ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR 20-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk Cem

Location

18 (a) Funeral director Roth & B. M. Walters

(b) Address PRATT & STRICKER Sts

19 (a) APR 19 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944 at 4 45 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from April 1 1944 to April 17 1944. and that I last saw h[illegible] alive on April 17 1944

Immediate cause of death: Cardiac failure — Duration

Due to Cerebral vascular episode

Due to hypertension

Other Conditions diabetes mellitus arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore Shorofsky MD

Address 601 N. Monroe Date signed 4/18/44

G 16366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

G 16366 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1744 William St. Balt
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1744 William St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME (Mrs.) Florence Margaret McNeir

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	W NF

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Charles McNeir
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1876

8. AGE: Years	Months	Days	If less than one day
67	6	0	29 hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name	John Keyser
	13. Birthplace	Baltimore, Md.
MOTHER	14. Maiden Name	Katherine Conroy
	15. Birthplace	Baltimore, Md.

16 (a) Informant Charles T. McNeir
(b) Address 5206 Anthony Ave, Balto
17 (a) Final (Burial, cremation, or removal) (b) Date thereof 4-22-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director Wilson Funeral Home
(b) Address 1211 W. Fayette St.
19 (a) (Date received by registrar) APR 19 1944 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944, at 11:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26 1944, to 4-18 1944, and that I last saw h er alive on 4-18 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	3 days
Due to Metastatic carcinoma	3 yrs.
Due to Carcinoma of breast	6 yrs.
Other Conditions Obstructive lymphedema of arm.	3 yrs.

(Include pregnancy within 3 months of death)
Date of operation March 4, 1944
Major findings of operation: Metastatic carcinoma in left axillary nodes
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Brown M. D.
Address Union Memorial Hospital Date signed 4-18-44

G 16367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 52B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Avenue
(c) Hospital or institution:
Home for the Aged of the Methodist Ch.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Boyd

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1863

8. AGE: Years	Months	Days	If less than one day
81	0	0	hr. min.

9. Birthplace Frederick, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Boyd
13. Birthplace Frederick, Maryland

MOTHER
14. Maiden Name Caroline Mantz
15. Birthplace Frederick, Maryland

16 (a) Informant Miss Coates
(b) Address 2211 Rogers Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 4/20, 43 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

APR 19 1944 (Date received by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944, at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1942 to April 17 1944, and that I last saw h/ alive on 4-17 1944.

Immediate cause of death: Malignancy of Bladder — Duration: 2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony J. Davies M. D.
Address 810 N. 33rd St. Date signed 4-18-44

G 16368
JL - 87511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16368 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
4940 Eastern Ave.
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 29 E. Mt. Vernon Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Havron

3 (b) If veteran, name war
3 (c) Social Security Account No. 2640 -7333

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1905

8. AGE: Years 38 | Months 5 | Days 17 | If less than one day hr min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation
11. Industry or business Brown & Heim Co.

FATHER
12. Name James Havron
13. Birthplace New York

MOTHER
14. Maiden Name Julia Middleton
15. Birthplace New York

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-23-44 (month) (day) (year)
(c) Cemetery or crematory Bolton Rural Cem.
Location Glen Falls, New York

18 (a) Funeral director Wm. J. Brehner
(b) Address North & Poppleton Ave

19 (a) APR 19 1944 Huntington Williams M.D. Registrar
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19- 1944 at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18- 1944 to 4-19- 1944, and that I last saw him alive on 4-19- 1944.

Immediate cause of death: pneumonia — Duration: 5 days (c)

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Ehrlich M. D.
Address 4940 Eastern Ave Date signed 4-19-44

G 16369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 117a

G 16369

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address North Broadway

(c) Hospital or institution: Church Home & Hosp. b'

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 7days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town ~~33 N. Luzerne Ave~~ (If outside city or town limits, write RURAL and give town)

(d) Street No. 33 N. Luzerne Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

V

3 (a) FULL NAME Ferdinand Hurxthal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-84

8. AGE: Years	Months	Days	If less than one day
59	10	24	hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Aircraft Worker

11. Industry or business Arsenal

FATHER: 12. Name Frederick Hurxthal

13. Birthplace Pennsylvania

MOTHER: 14. Maiden Name Jennie T Lamar

15. Birthplace Mass.

16 (a) Informant Mr. John H Yates

(b) Address 2729 Jefferson St, Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-01-44 (month) (day) (year)

(c) Cemetery or crematory Riverview

Location Romeverte, West Virginia

18 (a) Funeral director Harry H. Witzke

(b) Address 401 Edmondson Ave.

19 (a) (b)

(Burial, cremation, or removal) Huntington

APR 19 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18-~~44~~ 1944, at 1.50 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1944 to 4-18 1944, and that I last saw h~~im~~ alive on 4-18 1944.

Immediate cause of death Pneumonia

Due to Post-operative

Due to Gastric atony

Other Conditions Peptic Ulcer & Obstruct. Pyl. Opn, Gastric Atony

(Include pregnancy within 3 months of death)

Date of operation 3-21-44

Major findings of operations: Perf. Ulcer & Pyloric Obstruct.; Gastro-Duodenal & Marginal Ulcer

of autopsy: Bronchopneumonia; Gastric Dilatation

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Isabella Hanson M. D.

Address Church Home & Hosp. Date signed 4-18-44

16370 — G 16370

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 16370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3724 Cottage Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3724 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachael Zuckerwar (Shugar)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Late Isaac
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day hr.	min.
75				

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Jacob Sulsky
13. Birthplace RUssia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Reba Shugar
(b) Address 3724 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20, (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Blvd.
Location Landsdowne Md

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 APR 20 1944 (Date rec'd by registrar) (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1944 to April 19 1944. and that I last saw h[illegible] alive on April 16 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arterio-sclerosis	2 yrs
Due to Diabetes mellitus	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack Cohen M. D.
Address 1804 Eutaw Place Date signed 4/19/44

6371 9 16371 ✓ G 16371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 Rockrose Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4/12
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Rockrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Altfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Solomon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day hr.	min.
82				

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Asher Levin
13. Birthplace Poland

MOTHER
14. Maiden Name Goldie ?
15. Birthplace Poland

16 (a) Informant E. Milton Altfeld
(b) Address 2812 Rockrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 W North Ave

APR 20 1944

19 (a) (Date rec'd by registrar) Huntington Williams M.R

VS 280

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1944 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to April 19 1944, and that I last saw h alive on 4/19 1944.

Immediate cause of death coronary thrombosis Acute — Duration 36 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] MD

Address 2904 Remington Rd Date signed 4/19/44

G 16372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G 16372

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 Druid Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Roy Evans

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-12-0246

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age 1875 years

7. Birth date of deceased (mo., day, yr.) June 23, ~~1876~~

8. AGE: Years ~~68~~ | Months 9 | Days ~~15~~ 24 | If less than one day hr. min.

9. Birthplace Trenton, N. J.
(Town, county, and state)

10. Usual Occupation Post Office Dept.

11. Industry or business Retired

FATHER 12. Name John Evans

13. Birthplace N. J.

MOTHER 14. Maiden Name Margaret

15. Birthplace N. J.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Town
Location Baltimore, Md.

18 (a) Funeral director Mt. Francis A. Hemsley

(b) Address 518 W. Biddle St.

19 APR 20 1944 (c) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17 1944 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1944 to 4-17 1944 and that I last saw h/ alive on 4-17 1944.

Immediate cause of death. Pulmonary embolism — Duration 7

Due to Hypertensive cardiovascular disease without uremia — Duration ?

Other Conditions: Cerebral Thrombosis — Duration ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Mattman M. D.

Address B.C.H. Date signed 4-17-44

(over)

VS 150

G 16373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 16373 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai 137
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARION SNYDER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband ~~or wife~~ SAMUEL SNYDER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Balto Md (town, county, and state)
10. Usual Occupation Home Work
11. Industry or business

FATHER
12. Name Israel Fieldstein
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-44 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd
Location Windsor Mill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (Date received by Registrar) APR 20 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19 1944 at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1944 to 4/19 1944, and that I last saw her alive on 4/19 1944.

Immediate cause of death Pulmonary Edema — Duration

Due to Chronic Glom. Nephritis and Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 4/19/44

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Ucarte M.D.
Address Sinai Hosp. Date signed 4/19/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16374 ✓ 93D G 16374 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2544 Druid Park Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1 D

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2544 Druid Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

If yes, name country

3 (a) FULL NAME Hyman Cohen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Hyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day hr.	min.
51				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name ✓
13. Birthplace Russia

MOTHER
14. Maiden Name ✓
15. Birthplace Russia

16 (a) Informant Hyman Cohen
(b) Address 2544 Druid Park Drive

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4-20-44 (month) (day) (year)
(c) Cemetery or crematory Rogadala
Location Old Rd & Hamilton Ave
Carl Sayer Inc

18 (a) Funeral director 1432 E. Balto St
(b) Address

19 (a) APR 20 1944 Registrar
VS 180 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19 1944 at 8:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1944 to 4/19 1944, and that I last saw h[illegible] alive on 4/19 1944.

Immediate cause of death
(a) Acute Cardiac Failure
Due to (b) Pulmonary Edema
Due to (c) Chronic Hypertension

Duration
1 day
Unknown

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Coleman M.D.
Address 1921 W Lanvale Date signed 4/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 16375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164E

G 16375 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs +
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Callow Ave, (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kate Morris

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis Morris
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hyman David
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Sarah
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phil Rd & Bowleys Lane

18 (a) Funeral director Jos. Levy Son
(b) Address APR 19 1944 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19- 1944, at 9.45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured 5th & 6th Cervical vertebrae

Due to

Other Conditions Depressive Psychosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-19-44 at 3.30 A.M.
(b) Where did injury occur? 2628 Loyola Southway
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Jumped from front roof

23. Signature Howard J. Mallonee M.D. Medical Examiner.
Date signed 4-19-44

G 16376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 16376 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mayor ave
(c) Hospital or institution: West Baltimore Gen. Hosp. 15 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4412 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME COBURN C CROOK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-07-3825

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rolena S. (Lilly)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1884

8. AGE: Years	Months	Days	If less than one day
59	8	10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business A. E. Oppenheimer

FATHER
12. Name Harry P. Crook
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte Coburn
15. Birthplace Md.

16 (a) Informant Mrs. Rolena S. Crook
(b) Address 4412 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

APR 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944, at 6 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 1944, to 4-18 1944, and that I last saw him alive on 4-18 1944.

Immediate cause of death Cerebral hemorrhage — Duration

Due to (not traumatic)

Due to Hypertension and Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor
Address West Balto Gen. Hosp. Date signed 4/18/44 D.

G 16377

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92B

G 16377 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALPHONSUS FRANCIS CZYZ

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 111-10-9286

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1913

8. AGE: Years	Months	Days	If less than one day: hr.	min.
31	0	5		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Anthony Czyz
13. Birthplace Poland

MOTHER
14. Maiden Name Veronica Laminiski
15. Birthplace Poland

16 (a) Informant Rev. John A. Czyz
(b) Address Buckeystown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15 APR 24 1944 Hunter Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 18 1944 at 1 45 P.M.

21. I certify that I took charge of the remains described above, held an INSPECTION thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Valvular heart disease,
mitral insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.

Date signed 4-18-44

Every item on this certificate should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16378 ✓ G 16378

BALTIMORE CITY HEALTH DEPARTMENT

AB-86514

CERTIFICATE OF DEATH 47c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1165 Carroll St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Dickerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Bailey Tapkins

6 (c) If alive, give age years

7. Birth date of deceased (mo.) Sept- 8, 1885

8. AGE: Years 58 Months 8 [redacted] If less than one day hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Dickerson (D)
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine Cancermiller (D)
15. Birthplace Md.?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Fredrick Rd

18 (a) Funeral director Harry A. Wilke
(b) Address 4[illegible] Edmondson Ave

19 (a) APR 20 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1944, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1944, to 4/17 1944, and that I last saw h[illegible] alive on 4/17 1944.

Immediate cause of death: Bronchopneumonia, Ca, left lung

Duration: 3-4 wks.

Due to: Ca, left, lung

Due to:

Other Conditions: Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

Autopsy: Ca of left main bronchus with total atelectasis; bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Sergman M.D.

Address BCH Date signed 4/17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 180

G 16379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

G 16379

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Hilton Court Apartments
(a) Baltimore City, Maryland
(b) Street address 3306 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 3306 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millicent N. Aymold.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-09-8718

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7. 1918

8. AGE: Years 26 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Clerk.

11. Industry or business Motor Sales Co.

FATHER 12. Name B. L. Aymold.
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Dayse Tall
15. Birthplace Baltimore, Md.

16 (a) Informant Bernard L. Aymold
(b) Address 3306 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 APR 20 1944 (Date rec'd by registr.) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 18 1944 at 7.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 1944 to 4-18 1944.
and that I last saw h[illegible] alive on 4-18 1944.

Immediate cause of death Bilateral Pul. Tbc — Duration 3½ yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Edmund Levin

Address 3400 Hilton Rd. Date signed 4/18/44

G 16380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16380 Registered No. 1172

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address St. Joseph's Hosp - W. North Ave

(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 438 E Cross St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Howard E. Pinkine

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-7920

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	—

6 (b) Name of husband or wife Marjorie S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1896

8. AGE: Years	Months	Days	If less than one day
47	11	30	hr min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business Nat Warehouse Co

FATHER 12. Name James M Pinkine

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Linda Griffith

MOTHER 15. Birthplace Md

16 (a) Informant Mrs Marjorie L Pinkine

(b) Address 438 E Cross st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3806 Frederick Ave

18 (a) Funeral director William M. Mareck

(b) Address 715 Light St Williams, M.D.

APR 20 1944 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 18 1944 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1944 to 4-18 1944, and that I last saw h[illegible] alive on 4-8 1944

Immediate cause of death Stenal Fistula

Due to Uremia —

Due to Toxic Nephritis

Other Conditions Pyloric Ulcer.

(Include pregnancy within 3 months of death)

Date of operation 4 — 11 — 44

Major findings of operation: Pyloric Ulcer

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank L. Vanni, M. D.

Address St. Jos. Hosp. Date signed 4-18-44.

VS 250

G 16381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

G 16381 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 651 Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 16
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town 651 N. Bentalou St Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen Frances Russell

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nanetta Louise Kispert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26th 1867

8. AGE: Years 76 | Months 3 | Days 24 23 | If less than one day hr. min.

9. Birthplace Annapolis, Md. (Town, county and state)
10. Usual Occupation Civil Engineer
11. Industry or business Self.

FATHER
12. Name James G Russell
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Caroline Brown
15. Birthplace Annapolis Md.

16 (a) Informant Mrs Nanetta Louise Russell
(b) Address 651 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory Baldwin Mem. Gdns
Location Millersville, Md.

18 (a) Funeral director B. L. Hopping
(b) Address 172 West St. Annapolis, Md.

19 (a) (Date rec'd) (b) APR 20 1944 Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944, at 9 13 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1944 to April 19 1944 and that I last saw h[illegible] alive on April 19 1944.

Immediate cause of death
Squamous Cell Epithelioma of tongue - Metastasis to cervical glands
Due to
Due to
Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 6 Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J Rhoads MD 2302 Eutaw St. Date signed 4/19/44

C 16382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45

C 16382 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 Asquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 Asquith St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Coulter Henry Gilmore Coulter

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-24-6971

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) Dec. 18th, 1916

8. AGE: Years 27 | Months 4 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Gilmore Coulter
13. Birthplace Baltimore

MOTHER
14. Maiden Name Myrtle Meushaw
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Myrtle Coulter Bruno (Mother)
(b) Address 2455 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location East end of North Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) APR 20 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1944, at 9.45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Epilepsy Idiopathic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Ruth M.D. Medical Examiner
Date signed 4/19/44

VS 151

Please write plainly. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1218 G 16383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1828 Hope Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 Hope Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Wihm

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Kunigunda Wunner
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1855

8. AGE: Years	Months	Days	If less than one day
89	1	27	##### min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Stieff Pianos Mfg.

FATHER
12. Name John A. Wihm
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Raabe
15. Birthplace Germany

16 (a) Informant John A. O'Brien, (Grandson)
(b) Address 1813 Hope Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Ave

19 (a) APR 20 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 th 19 44 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/44 19 to 4/19 19 44, and that I last saw h. alive on 4/15/44 19

Immediate cause of death: Arteriosclerotic Heart Disease — Duration

Due to

Due to

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C. Smith
Address 2232 North Ave Date signed 4/20/44

G 16384

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16384 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2228 Penn. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 8yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Penn. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances M. Matthews Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Hen. W. Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1881

8. AGE: Years 62 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Towson Md Balto Co.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjaman Matthews
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Margaret Gassaway
15. Birthplace Balto. Co. Md

16 (a) Informant Emma Jackson
(b) Address 419 Schwartz Ave Govens Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-1944 (month) (day) (year)

(c) Cemetery or crematory Pleasant Rest
Location Towson Md Balto Co.

18 (a) Funeral director Byron Francis H. Wright
(b) Address 721 Aisquith St

19 (a) (Signature of registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1944, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 44 to 4/16 1944
and that I last saw h alive on 19

Immediate cause of death Central apoplexy
Due to Paralysis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dan R. Leitch M. D.
Address 139 W. Mt. Royal Ave Date signed 4/19/44

G 16385

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16385 Registered No. 166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 N Gay Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (William) Willie Diggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 34 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business Furniture Shipyard

FATHER
12. Name Thomas Jefferson
13. Birthplace Va

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Va.

16 (a) Informant Thomas Diggs
(b) Address 1744 E Chase St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 21 44 (month) (day) (year)

(c) Cemetery or crematory
Location Dinwiddie Virginia

18 (a) Funeral director Mrs Roberts Elliott & Daughter
(b) Address 112 N. Caroline St.

APR 20 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1944, at 6 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/16/44 at 1:15 A.M.
(b) Where did injury occur? 810 N Gay Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury shot during altercation

23. Signature H. L. Williams M.D.
Medical Examiner.
Date signed 4-18-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16386 Registered No. 1314

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Balto.
(a) Baltimore City, Maryland
(b) Street address 1352 Carroll Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1352 Carroll St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Williams.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: Colr
6 (a) Single, married, widowed, or divorced: Widowed —
6 (b) Name of husband or wife: James Weal —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown —

8. AGE: Years 61 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Housework —

11. Industry or business

MOTHER / FATHER
12. Name Richard Williams
13. Birthplace Balto.
14. Maiden Name Annie Wells.
15. Birthplace Balto.

16 (a) Informant Mildred Williams
(b) Address 1393 West Street.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4 23. 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemty
Location Balto.

18 (a) Funeral director Walter B. Price
(b) Address 1394 W. Hamburg St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944 at 12 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 1 1944 to Apr 20 1944, and that I last saw her alive on Apr 20 1944.

Immediate cause of death Uraemia
Hypertension
Nephritis
Due to Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Francescon M. D.
Address 192 W Lee Date signed 4/20/44

G 16387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16387

110a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Patton Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1927

8. AGE: Years	Months	Days	If less than one day
16	10	4	hr. min.

9. Birthplace Winnsboro, S.C. (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name George
13. Birthplace S.C.

MOTHER
14. Maiden Name Henrietta
15. Birthplace S.C.

16 (a) Informant Susie Mae Hall
(b) Address 3303 Payton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory Winnsboro
Location South Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) [illegible] Huntington Williams M.D. Registrar

APR 20 1944

MEDICAL CERTIFICATION

18

20. DATE OF DEATH April 19, 1944, at 10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Empyema 3
right chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 4-20-44

G 16388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G 16388 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 Street & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 22 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 Wendover Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Guy Crowther
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mrs. Irma M. Crowther
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 5 Sept 1868

8. AGE: Years 75 | Months 7 | Days 15 | If less than one day hr. min

9. Birthplace Crisfield, [redacted], Md.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Crowther
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Elizabeth Frances Bowlay
15. Birthplace Maryland

16 (a) Informant Mrs. Irma M. Crowther
(b) Address 219 Wendover Road Balto.

17 (a) Burial (b) Date thereof 4-22-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenwood Church
Location Cookeysville Md.

18 (a) Funeral director Bittinger & Co.
(b) Address 1224 N. Charles St.

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

APR 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944 at 2.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Mar. 1944 to 20 April 1944 and that I last saw him alive on 20 April 1944.

Immediate cause of death Cardio respiratory failure

Due to Asteriosclerosis

Due to diabetes mellitus

Other Conditions Carcinoma of prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J. Van Dilla M.D.
M. D.
Address Univ. Mem. Hosp. Date signed 4-20-44

G 16389

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 16389 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4701 Roland Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Roland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Martha E. Howser

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1866

8. AGE: Years	Months	Days	If less than one day
78	2	30	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Gasaway S. Howser
13. Birthplace Md.

MOTHER
14. Maiden Name Cecelia Bramwell
15. Birthplace Md.

16 (a) Informant Mrs. Nettie L. Skinner
(b) Address 4701 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. McHultz Home, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) (b) Registrar

APR 20 1944

VS 150

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944, to April 19 1944, and that I last saw her alive on April 19 1944.

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to Arteriosclerosis and	3 years
Due to Myocardial failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lantz M. D.
Address Temple Gardens Apts. Date signed 4/20/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Frederick ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country —

3 (a) FULL NAME Mrs. Emma A. Carroll

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Charles F. Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/1879

8. AGE: Years	Months	Days	If less than one day: hr.	min
65	2	14		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles Gerhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie
15. Birthplace Germany

16 (a) Informant Mrs Ernest Vaughan
(b) Address 1413 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director John O. Metzerott & Sons
(b) Address 1900 Eutaw Place.

19 (a) [illegible] Huntington Metzerott, Md.

APR 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944, at 7:01 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1944, to April 19 1944, and that I last saw h[illegible] alive on April 5 1944.

Immediate cause of death Pulmonary edema and anasarca — Duration —

Due to Heart failure (congestive) —

Due to Arteriosclerosis, Renal insufficiency —

Other Conditions Gangrene 3rd metatarsal 5 wks. Diabetes mellitus —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Anasarca, cardiac hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature L. Roy W. Tal[illegible] M. D.
Address University Hospital Date signed 4/19/44

G 16391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G 16391 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1621 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-85

8. AGE: Years 59 | Months 1 | Days 5 | If less than one day hr min

9. Birthplace New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Murphy
13. Birthplace N. Y.

MOTHER
14. Maiden Name Martha Hill
15. Birthplace Quebec

16 (a) Informant Friend
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 Broadway

APR 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19 1944 at 1150 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1944 to 4/19 1944 and that I last saw h[illegible] alive on 4/19 1944

Immediate cause of death: Respiratory failure

Due to Uremia

Due to nephritis due to

Other Conditions diabetes mel. + arteriosclerosis

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Barmingham M. D.
JHH
Address
Date signed 4/19

G 16392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G 16392 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden

(c) Hospital or institution: Md Genl Hosp. 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town) 2

(d) Street No. 909 Cathedral st (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Catherine Cavey

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-18-4795

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 20 1917

8. AGE: Years	Months	Days	If less than one day
26	6	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Book keeper

11. Industry or business Pa R.R.

FATHER

12. Name Miles Cavey

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Helen Hart

15. Birthplace Balto. Md.

16 (a) Informant Mrs Geo. Fischer

(b) Address 605 St. Paul st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st

19 (a) (b) Huntington Williams, M.D.

APR 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 19 1944, at 10 19/ PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1944, to 4-19 1944, and that I last saw h alive on 4-19 1944.

Immediate cause of death terminal T.B. pneumonia (?) — Duration

Due to Pulmonary T.B.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wilson Huntington Williams M.D.

Address Md. Gen. Hosp. Date signed

G 16393
XL - 87531

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16393
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3425 Hickory Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Geeslin

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elsie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1883

8. AGE: Years	Months	Days	If less than one day
60	11	8	hr min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Harrison R. Geeslin
13. Birthplace Va.

MOTHER
14. Maiden Name Emily Haffmaster
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Buried
(Burial, cremation, or removal)
(b) Date thereof 4/21/44
(month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Govanstown Balto Co

18 (a) Funeral director Milton Bird Sons
(b) Address 1217 E Fayette St

19 (d) APR 21 1944 Huntington Williams M.R.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19 1944 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1944 to 4-19 1944, and that I last saw h alive on 4-19 1944.

Immediate cause of death
Arteriosclerotic C-V Disease
Due to Cardiac Insufficiency
Due to Aneurysm Thoracic Aorta
Other Conditions Cellulitis both Legs
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Above

Duration
6 wks
>
6 wk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald B Hoff M. D.
Address Balto City Hosp Date signed 4-19-44

VS 150

G 16394

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G 16394 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Baltimore Gen. Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 431 Pitman Place (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME GOLDIE M. AMENT

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Albert Ament
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 1894

8. AGE: Years 49 | Months 7 | Days 23 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business at Home

FATHER
12. Name Philip Offelman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Casey
15. Birthplace Ellicott City, Md.

16 (a) Informant Albert Ament
(b) Address 431 Pitman Place

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/21/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st.

19 (a) APR 21 1944 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944 at 10.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 19 44. to 4-18 19 44.
and that I last saw her alive on 4-18 19 44.

Immediate cause of death: Cerebral hemorrhage
Due to (not traumatic)
Due to Hypertensive Arteriosclerosis
Other conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor
Address West Balto. Gen. Hosp. Date signed 4/19/44

VB 150

G 16395

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16395 Registered No.

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 N. Fulton Ave.
(c) Hospital or institution:

15-17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** SADIE FRANCES FRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George M. Fry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1869

8. AGE: Years	Months	Days	If less than one day
74	4	27	hr min.

9. Birthplace Salisbury, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Zeddie Gordy
FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Sallie Humphreys
MOTHER 15. Birthplace Md.

16 (a) Informant Mr. Zeddie Breithaupt
(b) Address 1914 Cecil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Belto., Md.

19 (Signature of Registrar) Huntington Williams M.D. Registrar

APR 21 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 19, 1944, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1944 to April 19 1944.
and that I last saw h[illegible] alive on April 18 1944.

Immediate cause of death Broncho pneumonia — Duration 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Corbman M.D.
Address 1512 W. North Ave. Date signed 4/20/44

G 16396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 877

✓ G 16388 Registered No. 3071

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkins
(c) Hospital or institution: S.T. Agnes Hospital 2 8 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508. Charing Cross (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Inez V. Bassler (Inez)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife Charles W. Bassler,

6 (c) If alive, give age 57

7. Birth date of deceased (mo., day, yr.) March 15. 1891

8. AGE: Years	Months	Days	If less than one day
53	1	4	hr. min

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Henry Pines,
13. Birthplace Virginia

MOTHER
14. Maiden Name Alice George,
15. Birthplace Virginia

16 (a) Informant Charles Bassler,
(b) Address 508 Charing Cross

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 22 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 (a) APR 21 1944 Huntington-Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 1944, to 4/19 1944, and that I last saw h[illegible] alive on 4/19 1944.

Immediate cause of death Multiple Sclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edith Rowley M.D.
Address St. Agnes Hosp. Date signed 4/19/44

G 16397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2 5
(e) Length of stay in Baltimore (yrs., mos., or days) 77yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RUR and give town)
(d) Street No. 3134 Howard Road (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Laura Sweetman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow

6 (b) Name of husband or wife George Sweetman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1866

8. AGE: Years	Months	Days	If less than one day
77	9	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Horn
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Laura Ray
(b) Address 3134 Howard Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21 44 (month) (day) (year)
(c) Cemetery or crematory St. Mary
Location Hampden

18 (a) Funeral director Thomas B. Donovan
(b) Address 2617-17 Eastern Ave.

APR 21 1944
(Date received by Registrar)

(b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19/44 19 . at 6 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/44 19 . to 4/19/44 19 . and that I last saw h alive on 4/19/44 19 .

Immediate cause of death
Bulbar Paralysis — Duration 3 weeks
Due to
Due to
Other Conditions Senile Atrophy - Sclerosis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Block M. D.
Address Franklin Square Hosp. Date signed 4/19/44

VS 8

G 16388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G 16388 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw Place & Brooks Lane
(c) Hospital or institution: Esplanade Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-L
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME CARRIE M. HALLE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Meyer S. Halle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1873

8. AGE: Years 70 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Mann,
13. Birthplace Germany.

MOTHER
14. Maiden Name Hannah Simpson,
15. Birthplace Germany.

16 (a) Informant Mr. Simon M. Halle,
(b) Address 5814 Clover Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Chas. Sonneborn & Son
(b) Address 1902 Eutaw Place

19 (a) Apr 21 1944 (b) Registrar, Baltimore, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 19, 1944 at 11.55 P

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1943. to April 19 1944
and that I last saw h[illegible] alive on April 18 1944.

	Duration
Immediate cause of death: Carcinomatosis	8 mos
Due to: Carcinoma of Breast	4½ yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place Date signed 4-20-44

G 16399

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

G 16399

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard + Madison
(c) Hospital or institution: Md. Gen. Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 49

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Hollen Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Mrs. Kathryn Hurd

3 (b) If veteran, name war ..... 3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife E Alfred Hurd 6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 9, 1894

8. AGE: Years	Months	Days	If less than one day
49	10	9	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Geo W. Gross
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Volz.
15. Birthplace Baltimore

16 (a) Informant E Alfred Hurd
(b) Address 414 Hollen Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem. Co.
Location City
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St.
19 APR 21 1944 (Date received by Registrar) (b) Huntington Williams, M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1944, to April 18 1944, and that I last saw her alive on April 18 1944.

Immediate cause of death Carcinoma of left breast

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature H. Vernon Williams M. D.
Address Md. Gen. Hosp. Date signed 4-18-44

451483

G 16400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 57D

G 16400

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6560 St Helena Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Virginia Weigandt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-37

8. AGE: Years	Months	Days	If less than one day
6	6	7	hr min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

MOTHER / FATHER

12. Name Leonard Weigandt

13. Birthplace Md

14. Maiden Name Nina Stewart

15. Birthplace Md.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-44 (month) (day) (year)

(c) Cemetery or crematory Oaklawn Cem.

Location Baltimore

18 (a) Funeral director Maynard J. Covington

(b) Address 21 W. 25th St.

19 (a) (Signature of local registrar) Registrar

APR 21 1944

Huntington Mitchell, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944 at 8½ M

21. I certify that death occurred on the date above stated, that I attended deceased from Mar 23 1944 to April 19 1944 and that I last saw h[illegible] alive on April 19 1944

Immediate cause of death Respiratory Paralysis

Due to Brain Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John R Birmingham JNH

Address Date signed 4/19

452857

G 16401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16401 No. 124 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Ft Pierce
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Jane Burnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-19-43

8. AGE: Years | Months: 6 | Days: 1 | If less than one day: hr min.

9. Birthplace Tupas (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Floyd Burnett
13. Birthplace Texas

MOTHER
14. Maiden Name Ruth Kain
15. Birthplace Kansas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)

(c) Cemetery or crematory Bonhyam, Tyler
Location

18 (a) Funeral director John D. Mitchell Funeral Home
(b) Address 1901 Eutaw Place

19 (a) APR 21 1944 (Date received by Registrar) Registrar for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 18 1944 to Apr 20 1944 and that I last saw him alive on Apr 20 1944

Immediate cause of death Hemorrhage from esophageal varices — Duration

Due to Cirrhosis of liver

Due to Biliary atresia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Biliary atresia

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Lenard M. D.
Address Johns Hopkins Hosp Date signed 4-21-44

G 16402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16402 Registered No.

122a Baltimore

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hosp. 6-5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in ~~Baltimore~~ Dundalk (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Hargate 123 Williams Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 Williams Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Kifer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Walter Kifer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 7 - 1900

8. AGE: Years	Months	Days	If less than one day
43	4	13	hr. min.

9. Birthplace Columbia, S. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W Cook
13. Birthplace South Carolina

MOTHER
14. Maiden Name May Heron
15. Birthplace S. C.

16 (a) Informant Hospital Record
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Apr 24/44 (month) (day) (year)
(c) Cemetery or crematory Edgewood Mem Gdns
Location
18 (a) Funeral director Philip Henrig Sons
(b) Address 2124 Eastern Ave
19 (a) APR 21 1944 Registrar
(Date received)
Huntington Pittsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29 1944, to 4-20 1944, and that I last saw her alive on 4-20 1944.

Immediate cause of death Uremia — Duration 4 days

Due to Toxic Nephrosis — ?

Due to Strangul. Red Umbilical Hernia & fecal extravasation

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
Subjective Tongue Ant. Abd wall etc.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Keller M. D.
Address Church Home + Hospital Broadway + Fairmont. Date signed 4-20-44

G 16403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G 16403

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3227 Burleith Ave
(c) Hospital or institution:

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3227 Burleith Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

3 (a) FULL NAME Dona Simonoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alexander Chertkoff
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Hyman Simonoff
(b) Address 3227 Burleith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-44 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Road
Location

18 (a) Funeral director Jack Pereira Inc
(b) Address 1439 E. Baltimore St

19 APR 21 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944 at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to April 21 1944.
and that I last saw h[illegible] alive on April 20 1944

Immediate cause of death: Carcinoma of liver — Duration: 6 mos

Due to

Due to

Other Conditions: Arterio-sclerosis 15 yrs with hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack Cohen M. D.
Address 1804 Eutaw Place Date signed 4/21/44

452684

G 16404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

G 16404 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Smith

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-02

8. AGE: Years 41 | Months 7 | Days 3 | If less than one day: hr. min.

9. Birthplace DC (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

MOTHER / FATHER

12. Name William ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace

16 (a) Informant Record

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 21 44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1442 E. Preston St

19 APR 21 1944 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1944 at 2 58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1944 to April 18 1944 and that I last saw h alive on April 18 19 44

Immediate cause of death: Uremia

Due to: Chronic glomerulo-

Due to: nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Date of autopsy 4/19/44 Glomerulonephritis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R Birmingham M. D.

Address JHH Date signed 4/19/44

VS 150

G 16405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 16405 Registered No. 3698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 16
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Stricker St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Eliza Jane Riley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	widowed

6 (b) Name of husband or wife St Clair Riley
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1870

8. AGE: Years	Months	Days	If less than one day
73	4	14	— hr. — min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business own home

FATHER
12. Name James Brown
13. Birthplace maryland

MOTHER
14. Maiden Name Barbara Caston
15. Birthplace Virginia

16 (a) Informant Mrs Elizabeth King
(b) Address 920 Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley ave

19 APR 21 1944 (b) Huntington Williamsport Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18- 1944, at 3:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1944, to 4-18 1944, and that I last saw her alive on 4-17- 1944.

Immediate cause of death: Cerebral hemorrhage — Duration: 4 days

Due to arterio Sclerosis & hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders, M. D.
Address 1029 Stricker St - Date signed 4-18-44

G 16406 452473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

G 16406
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 N Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Fitchett
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-97

8. AGE: Years	Months	Days	If less than one day
46	7	8	hr min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name John Fitchett
13. Birthplace VA

MOTHER
14. Maiden Name Minnie Sullivan
15. Birthplace Holland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 4-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 6600 Baltimore Nat'l Pike

19 (a) APR 21 1944 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 17 1944, at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 12 1944, to Apr 17 1944, and that I last saw him alive on Apr 17 1944.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Heart Disease	2yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Anatomical Diag.

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Johns Hopkins Hosp M. D.
Date signed 4/18/44

VS 150

G 16407
JL - 87378

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

G 16407
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Chester

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1884

8. AGE: Years	Months	Days	If less than one day
60	1	0	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Allen Chester
13. Birthplace N. C.
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy O. Wilson
18 (a) Funeral director
(b) Address Bradley and
19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) APR 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18- 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10- 1944, to 4-18- 1944, and that I last saw him alive on 4-18- 1944

Immediate cause of death Hypertensive C-V. Disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
a post embolic infarction
of autopsy terminal pneumonia & recent hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel E. Erlich M. D.
Address 4940 Eastern Ave Date signed 4-19-44

VS 150

G 16408

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 16408 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1145 E. Lombard Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Pack

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/8/44

8. AGE: Years | Months | Days 11 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name William Earl Pack
FATHER 13. Birthplace Giles Co. Va.

MOTHER 14. Maiden Name Gracie May Stewart
MOTHER 15. Birthplace Giles Co. Va.

16 (a) Informant William Earl Pack
(b) Address Giles Co. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24 44 (month) (day) (year)
(c) Cemetery or crematory Pack's Burial Ground
Location Pearisburg Va.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) (Date rec'd by registrar) APR 21 1944 Huntington Wallace, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1944, at 11:30 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy/Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Asphyxiation

Due to vomitus.

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-21-44 9:30 A. M. 3/2
(b) Where did injury occur? 1145 E. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury asphyxiation due to vomitus.

23. Signature H. L. W. Gallenweber M.D. Medical Examiner
Date signed April 26, 1944.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The [illegible] WITH UNFADING INK.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 16409 94a

✓ C 16409 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 Darley Avenue
(c) Hospital or institution:

9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 Darley Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinan Frederick Younghein

3 (b) If veteran, name war	3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary A. McGraw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/28/62

8. AGE: Years	Months	Days	If less than one day
81 yrs	5	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Police - retired
11. Industry or business

FATHER
12. Name John Younghein
13. Birthplace Germany

MOTHER
14. Maiden Name Muth
15. Birthplace Germany

16 (a) Informant wife
(b) Address 1232 Darley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

(c) [illegible] Huntingtn Williams, MD

APR 21 1944

VS 148

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1944 to April 19 1944 and that I last saw him alive on April 19 1944

Immediate cause of death Coronary Thrombosis — Duration days

Due to Coronary atherosclerosis ?

Due to Senile atherosclerosis

Other Conditions Hypertrophied prostate

Cancer bladder

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary A. McGraw
Address 1200 E. Preston Date signed 4/19/44

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16410 (Registered No.)

G 16410

940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N CAROLINE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA B. ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 58 | Months | Days | If less than one day: hr. min.

9. Birthplace Bolo., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Barnes
13. Birthplace Md

MOTHER
14. Maiden Name Annie
15. Birthplace Va.

16 (a) Informant John Reach
(b) Address 932 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-1944 (month, day, year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co, Md

18 (a) Funeral director Byron Maria V. Wright
(b) Address 721 Biddle St

19 (a) (Date received by Registrar) (b) Huntington Williams M.D.

APR 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 19 44 at 12 A M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to hey death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenhorst M.D.
Medical Examiner

24. Date signed 4/19/44

G 16411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 16411

Registered No. 1008

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Caroline
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ m
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Rosedale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 N. Wolfe St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME FLORENCE MAY HOPE DOWNS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Howard Elmer Downs
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Jan. 19. 1909

8. AGE: Years	Months	Days	If less than one day
35	3	1	hr. min.

9. Birthplace Swampscott Mass.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Pino
13. Birthplace Italy ?

MOTHER
14. Maiden Name Not Known
15. Birthplace Italy ?

16 (a) Informant Mr. Howard E. Downs
(b) Address 1900 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 24. 1944 (month) (day) (year)
(c) Cemetery or crematory New Freedom Cemetery
Location New Freedom. Penna

18 (a) Funeral director HENRY SANDER & SONS. INC.
Address North Ave. & Broadway.

19 (a) APR 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/[illegible] 1944, at 10 5' A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1944 to 4/[illegible] 1944, and that I last saw h[illegible] alive on [illegible] 19[illegible].

Immediate cause of death — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G 16412 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cooperation of physicians is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3434 Lyndale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3434 Lyndale Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY KAUFMAN DIGGS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 218-07-9157

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isabella W. Diggs

6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): January 19, 1869

8. AGE: Years 75 | Months 3 | Days 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Shipping Clerk

11. Industry or business: J. E. Smith-Box Mfg.

FATHER
12. Name: William James Diggs
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Katherine F. Warr en
15. Birthplace: Virginia

16 (a) Informant: Mrs. Henry W. Diggs
(b) Address: 5808 Belle Vista Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: North Ave. & Broadway

APR 21 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944, at 10.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 6 1944 to Apr 20 1944 and that I last saw h[illegible] alive on [illegible] 20 1944

Immediate cause of death: Acute Bronchitis
Duration: 7days.

Due to: Influenza

Due to:

Other Conditions: Myocarditis
Degeneration
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Harry Burke

Address [illegible] Date signed 4/20/44

HAL[illegible] C. HYDE

G 16413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G 16413 Registered No.

1. PLACE OF DEATH
(a) Baltimore City, Maryland Baltimore Md.
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Jenkins Memorial Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Cadogan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1857

8. AGE: Years 86 Months 10 Days If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and State)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thos Cadogan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Murphy
15. Birthplace Ireland

16 (a) Informant Mrs Jas L Ball
(b) Address 642 Charles Ave 4-24-44

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director George A Farley
(b) Address Fulton & Fayette

19 (a) Date received by registrar APR 21 1944 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1944, at 8 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to Fracture of left femur.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-12-44 at — M. 25/1
(b) Where did injury occur? Jenkins Memorial Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Slipped & fell in bathtub,

23. Signature [illegible] M.D.
Medical Examiner.
Date signed April 21, 1944.

If any of the above information is unknown, write UNKNOWN in it. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16414 ✓ G 16414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 110a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. High St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Angie E. Akin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 19 1879

8. AGE: Years	Months	Days	If less than one day
65		2	hr min.

9. Birthplace Wisconsin (Town, county, and state)

10. Usual Occupation Retired Missionary

11. Industry or business

FATHER
12. Name M. R. Akin
13. Birthplace Wisconsin

MOTHER
14. Maiden Name Mary Elizabeth Hatch
15. Birthplace Wisconsin

16 (a) Informant Mrs N.A. Southland
(b) Address 217 N. High St. Balto.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-24-44 (month) (day) (year)
(c) Cemetery or crematory
Location Greenmount

18 (a) Funeral director George A. Fuhrman
(b) Address Sedon & Fayette Huntington Ave Phila, Pa.

19 (a) (Date received by registrar) (b) Registrar

APR 21 1944 VS 150

Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944, at 2:55 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3/12 1944 to 4/21 1944 and that I last saw her alive on 4/21 1944.

Immediate cause of death	Duration
Pneumococcal Meningitis	4 days
Due to Pneumococcal Empyema	5 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/6/44

Major findings of operation: Pneumococcal Empyema

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C P Bray M.D.
Address Mercy Hosp Date signed 4/21/44

G 16415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

G 16415

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town SPARROWS Pt (If outside city or town limits, write RURAL and give town)
(d) Street No. North Pt Rd & Wise Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RONALD GAWLIK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/44

8. AGE: Years	Months	Days	If less than one day
	2	5	hr min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Julius Gawlik
13. Birthplace Balto Md

MOTHER
14. Maiden Name Loretta Bocklage
15. Birthplace Balto - Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 22 44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director Lilly & Zeller Inc
(b) Address Eastern Ave & Wolfe St.

19 APR 21 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APR - 21 1944 at 6 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from APR 20 1944 to APR 21 1944 and that I last saw h/M alive on APR 21 1944.

Immediate cause of death	Duration (Interval)
respiratory failure	
Due to pneumococcal meningitis	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp Date signed 9-21-44

VS 160

G 16416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G 16416 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Argonne Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Argonne Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE C. CLEMSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Carl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1892

8. AGE: Years	Months	Days	If less than one day
51	10	19	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Ass't. Buyer
11. Industry or business May Company

FATHER
12. Name John J. Goodmanson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Hodges
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. LeRoy Wm. Bode
(b) Address 926 Argonne Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) APR 21 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19xx to 4/20 19xx and that I last saw her alive on 4/20 19xx

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 5703 Harford Rd Date signed 4/21/44

G 16417

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G 16417 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OTTO MUELLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Rebecca M. Mueller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1860

8. AGE: Years	Months	Days	If less than one day
83	6	16	hr min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John A. Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Theresa M. Davis
(b) Address 2011 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) APR 21 1944 (b) Huntington Williams M.D. (Registrar) Address

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1944, at 12:01 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 6. 1944 to Apl. 20 1944. and that I last saw h alive on Apl. 19. 1944.

Immediate cause of death

Due to Chronic Myocarditis

Due to Old Age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: many years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jr Lieut. C Blake M. D.
Address Med. auto Bldg
Date signed 4/21/44.

G 16418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

✓ G 16418 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Universit Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1721 West Franklin St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Robert Fleeks

3 (b) If veteran, name war NO
3 (c) Social Security Account No. Infant

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Dec. 29th 1944

8. AGE: Years	Months	Days	If less than one day
	32	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Robert Harrison
13. Birthplace ?

MOTHER
14. Maiden Name Mamie Fleeks
15. Birthplace ?

16 (a) Informant Mamie Fleeks
(b) Address 1721 West Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Martin R. Williams
(b) Address 322 N. Dolphin St.

19 (a) (Date received) (b) Registrar

APR 21 1944

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19 1944, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19/44 to 4/19/44 and that I last saw h alive on 4/19 1944

Immediate cause of death: General Debilitation — Duration
Due to: Dehydration
Due to: Malnutrition
Other Significant Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifford Randall M. D.
Address University Hosp Date signed 4/21/44

G 16419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16419 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~~3 days~~ Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 N. Bentalou St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Lloyd Lowder Lambie.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Thelia Dorsey Lambie.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1896

8. AGE: Years	Months	Days	If less than one day: hr.	min
47	10 11	3		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Salesman.
11. Industry or business

FATHER 12. Name William Lambie.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Zenobia McKay
15. Birthplace Maryland.

16 (a) Informant patient
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director HARRY H WITZKE
(b) Address 4101 EDMONDSON AVE.

APR 21 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1944 at 2:13 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1944 to 4/20 1944, and that I last saw him alive on 4/20 1944

Immediate cause of death: Cardiac impotency failure.
Due to: cerebral embolism.
Due to:
Other Conditions: (Include pregnancy within 3 months of death)

Duration

Date of operation 4/18/44
Major findings of operation: Fracture lamina L4 ~~and~~
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Chaffee, M.D.
Address Union Memorial Hospital - Baltimore 18 Date signed 4/20/44

approved by Howard J. Madden, M.D.

G 16420 BALTIMORE CITY HEALTH DEPARTMENT G 16420
Wyrwas CERTIFICATE OF DEATH 61 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 237 S. Collington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Zone 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 S. Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josepha Wyrwas
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John Wyrwas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1869

8. AGE: Years	Months	Days	If less than one day
75	1	-	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Braciszewski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Anna Swann
(b) Address 237 S. Collington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Balto City

18 (a) Funeral director John M. Welsh
(b) Address 461 S. Chester Street

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

APR 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1944 to April 19 1944 and that I last saw h alive on 19

Immediate cause of death Diabetic Coma
Myocardial Insufficiency
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony Tumasonis M. D.
Address 2579 Foster ave - Date signed

4572 40

G 16421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82B

G 16421 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Montgomery

(c) City or town Silver Spring (If outside city or town limits, write RURAL and give town)

(d) Street No. 111 Saint Laurence Dr. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Helen Jester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-09

8. AGE: Years	Months	Days	If less than one day
35	2	15	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Day

13. Birthplace Md

MOTHER 14. Maiden Name Nannie Raines

15. Birthplace Va

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Columbia Cemetery

Location Columbia, Maryland

18 (a) Funeral director F. Arthur Walters

(b) Address 26-4 Carroll St. N.W. Takoma Park, D.C.

19 (a) (b)

APR 21 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944 at 9 27 a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1944 to Apr 21 1944 and that I last saw deceased alive on Apr 21 1944

Immediate cause of death Ventricular Fibrillation — Duration 5 min.

Due to Myocardial Ischemia — ?2mo.

Due to Periarteritis Nodosa — ? 1½yrs

Other Conditions? Cerebral Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Emil Oschner M. D.

Address 3145 Prospect St., N.W. Date signed 4-21-44

G 16422

JO #85936 G 16422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 49a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Glen Arm (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hoffman (Mary Lillian Hoffman)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1893

8. AGE: Years	Months	Days	If less than one day
51	3	1	hr min

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Bottling

FATHER: 12. Name Philip William Hoffman (d)
13. Birthplace ?

MOTHER: 14. Maiden Name Mary Matilda Whiteford (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Hilda Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by Registrar) (b) Huntington Williams M.D.
APR 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1944, at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1944, to 4-18 1944, and that I last saw h alive on 4-18 1944.

Immediate cause of death

Due to Carcinoma of Ovary with metastases

Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-11-44

Major findings of operation: Above

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald A Kelly M.D.
Address Balto City Hosp Date signed 4-19-44

G 16423
JL - 87491

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 16423
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully entered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Roper

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
W	NONE	M	W	Div.

6 (b) Name of ~~husband or~~ wife Florence Roper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1870

8. AGE: Years	Months	Days	If less than one day
73	7 M	25 26	hr min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Plumber

FATHER
12. Name John Roper
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Edwards
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director William Ehrlich
(b) Address 1217 Hollins St

APR 22 1944 (a) (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 1944, at 5 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1944 to 4-20 1944, and that I last saw ~~him~~ alive on 4-20 1944

Immediate cause of death: Bronchopneumonia — Duration: 5 da

Due to: Uremia — ?

Due to: Benign Prostatic Hypertrophy — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald B. Reed M. D.
Address Balto City Hosp Date signed 4-21-44

G 16424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G 16424

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired for, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 4/19/44
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

12-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Gilman Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP T. POST

3 (b) If veteran, name war	3 (c) Social Security Account No.
World's War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel McCaw
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 6/13/1880

8. AGE: Years	Months	Days	If less than one day
63	29 10	8 7	hr. min.

9. Birthplace New Bedford, Mass. (Town, county, and state)
10. Usual Occupation Court Reporter 4/12/44
11. Industry or business

FATHER
12. Name Henry Post
13. Birthplace New Bedford, Mass.

MOTHER
14. Maiden Name Ann Tillinghost
15. Birthplace S. Dartfouth, Mass.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 APR 22 1944 Registrar Washington Williams, M.D.

VS 180

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Apr. 20, 1944, at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 19, 1944 to Apr. 20, 1944 and that I last saw him alive on Apr. 20, 1944

Immediate cause of death 1. Generalised arteriosclerosis with marked sclerosis of circle of Willis;
2. Cardiac hypertrophy & dilitation;
3. Edema & congestion of brain & lungs

Duration
Unk.
Unk.
1 week

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Findings of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify) (Specify yes or no)
(e) Means of injury

23. Signature S E Jones O.D.
Address Baltimore, Md. Date signed 4/21/44

Va-1c 129

16425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G 16425 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Cranston Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City or town~~ Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Cranston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Filomana Nicolai

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband Augustine Nicolai
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30th 1863

8. AGE: Years	Months	Days	If less than one day
80	4	19	hr. min.

9. Birthplace Italy
(Town, county and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Frank Caccetti
13. Birthplace Italy

MOTHER
14. Maiden Name Francesca (Unknown)
15. Birthplace Italy

16 (a) Informant Flaminio Nicolai
(b) Address 2927 Ohio Ave Balto. Highlands

17 (a) Burial (b) Date thereof 4/22/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) ~~Cemetery or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

APR 22 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19th 1944, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 9, 1944, to Apr 19, 1944, and that I last saw h[er] alive on Apr. 19, 1944.

Immediate cause of death Lobar Pneumonia — Duration 9 days

Due to

Due to

Other Conditions Arterial hyper. tension, Myocarditis supp.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cassard M. D.
Address 5-14 Druid Lane Date signed 4/22/44

G 16426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G 16426

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 Kenhill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 Kenhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carrie M. Bauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ John Bauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1st 1885

8. AGE: Years	Months	Days	If less than one day
58	10	20	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name David McCullough
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine White
15. Birthplace Balto. Md.

16 (a) Informant John Bauer
(b) Address 1328 Kenhill Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/24/44 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Emmanuel
Location Balto. Md.

18 (a) Funeral director William Cook, Inc
(b) Address 127 W. Paul St Huntington Indiana, M.P.

19 APR 22 1944 (Date received) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1944, at 11 a.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 16 1944 to Apr 21 1944 and that I last saw h[illegible] alive on Apr 21 1944

Immediate cause of death: acute dilatation of Heart — Duration: 5 min

Due to Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 3156 Garrison Blvd Date signed 4/21/44

G 16427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G 16427

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4037 Belleau
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4037 Belleau (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Eleanor Lowry Wright

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James S. Wright
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 4 1861

8. AGE: Years 83 | Months 3 | Days 16 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name James Donaldson Lowry
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Dutton
15. Birthplace Baltimore Md

16 (a) Informant Mr. R. N. Wright (Son)
(b) Address 4037 Belleau

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Apr-22-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Sherwood Mourn Co.
(b) Address 108 W. Mt. Royal Ave.

APR 22 1944 (Delivered by undertaker) Harry [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944 at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1943 to April 1944, and that I last saw h[illegible] alive on 4-20 1944.

Immediate cause of death: Cerebral hemorrhage — Duration 8 mo.
Due to arterio-sclerosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. Dawn Moore M. D.
Address 3107 Belair Rd Date signed 4-20-44

G 16428

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16428

Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josh's Hosp - 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5714 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Edward Hueter (Hueter.)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16 62

8. AGE: Years	Months	Days	If less than one day
81	7		hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Conrad Hueter
13. Birthplace —

MOTHER
14. Maiden Name Catherine —
15. Birthplace —

16 (a) Informant Mrs Sarah E Hueter
(b) Address 5714 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-44 (month) (day) (year)
(c) Cemetery or crematory Loud-n Pdr.
Location

18 (a) Funeral director Leonard Hook
(b) Address 5305 Harford Rd

19 (a) APR 22 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 1944 at 4:40 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1944 to 4-20 1944, and that I last saw h[illegible] alive on 4-20 1944.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension - Arteriosclerosis

Due to Fall - Fractured Lt. Hip

Other Conditions Fractured (Lt Hip) Reduction - east

(Interval between onset and death)

Date of operation 4-19-44

Major findings of operation: Fractured Lt. Hip.

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: over
(a) Accident, suicide, or homicide Acc
(b) Date of occurrence April 17, 1944 a.m. p.m. M
(c) Where did injury occur? Back yard of home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell while putting lawn roller away

23. Signature Frank L. Dame M. D.
Address St. Jos. Hosp. Date signed 4-20-44

Affirmed by Howard T. Wilson, M. D.

S 16429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

S 16429 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University Hosp 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 612 W Mulberry St. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Dorsey

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Infant

6 (b) Name of husband or wife: NA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/10/44

8. AGE: Years	Months	Days	If less than one day
		8	hr. min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Harry Dorsey

13. Birthplace ?

MOTHER 14. Maiden Name Mandy Padden

15. Birthplace ?

16 (a) Informant Mandy Dorsey

(b) Address 612 west Mulberry St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location UNIVERSITY MEDICAL SCHOOL APR 21 1944 Commissioner of Health

18 (a) Funeral director

(b) Address

APR 22 1944 Huntington Williams MR (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/44 19 , at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/44 19 , to 4/12 19 44, and that I last saw her alive on 4/12 19 44.

Immediate cause of death	Duration
Failure of Development	
Due to Premature	
Due to Fell 7 ft.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: No

of autopsy: No

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Cliff Rainitt M. D.

Address University Hosp Date signed 4/13/44

0884

C 16430

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

C 16430 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 W Saratoga (If rural give location)
(e) Citizen of foreign country? (or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Infant

6 (b) Name of husband or wife Marie Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/44

8. AGE: Years	Months	Days	If less than one day
		6	hr. min

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Swamy ? Lee
13. Birthplace

MOTHER
14. Maiden Name Maria Austin ?
15. Birthplace

16 (a) Informant Marie Lee
(b) Address 1622 W. Saratoga St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 21 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

APR 22 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

0885

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1944, at 3:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1944, to 4/17 1944
and that I last saw h alive on 4/16 1944

Immediate cause of death: failure of development
Due to: premature
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Ralliff M.D.
Address University Hosp Date signed 4/17/44

G 16431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161 C

G 16431

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Univ. Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 das.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 das.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Madison ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? [redacted] years

3 (a) FULL NAME Baby Boy Logan

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-12-44

8. AGE: Years	Months	Days	If less than one day
0	0	7 6	— hr. — min.

9. Birthplace Baltimore City Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name John Logan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dorothy American
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Dorothy Logan
(b) Address 1700 Madison Av.

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location UNIVERSITY MEDICAL SCHOOL APR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address .....

19 (a) APR 22 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18 1944, at 3.48 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1944, to 4-18 1944, and that I last saw him alive on 4-18 1944.

Immediate cause of death: Probable respiratory failure — Duration: .....
Due to Cerebral anoxemia — 7 das.
Due to Intrauterine anoxemia (mother Eclamptic) Cerebral Hyperemia
Other Conditions .....
(Include pregnancy within 3 months of death)
Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....
23. Signature Alfred T. Nelson M. D.
Address Lawrenceville, Va. Date signed 4-19-1944

0886

C 16432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 16432 Registered No. 160a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2 [illegible]~~ 616 W Mulberry (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Girl Gray

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Infant

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/44

8. AGE: Years	Months	Days	If less than one day
		8	hr. min

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Ella Gray ?
15. Birthplace

16 (a) Informant Ella Gray
(b) Address ~~2 [illegible]~~ 616 W Mulberry

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 22 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

F 0887

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19/44 19 . at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18/ 1944 to 4/19 1944
and that I last saw h er alive on 4/19 1944.

Immediate cause of death
Cerebral Hemorrhage

Due to
Prematurity.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Capt Ratcliff M.D.
M. D.
Address University Hosp Date signed 4/20/44

G 16433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G 16433 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 20 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12 20 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 624 West Lee Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Temple "B"

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife Infant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/19/44

8. AGE: Years | Months | Days | If less than one day 12 hr. 20 min

9. Birthplace University Hosp Balto (Town, county, and state)

10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Lottie Temple
15. Birthplace ?

16 (a) Informant Lottie Temple
(b) Address 624 West Lee St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 22 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

0858

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19/44 19 , at 12 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18/44 19 , to 4/19/44 19 , and that I last saw h[illegible] alive on 4/19/44 19 .

Immediate cause of death — Duration

Due to Premature Birth

Due to Feeble to develop

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Capt Raitt M.D.
M. D.
Address U Md Hosp Date signed 4/19/44

G 16434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G 16434 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-44 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4323 Wickford Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene N. Curtis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Blanche O. Curtis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1880

8. AGE: Years	Months	Days	If less than one day
63	9	27	hr. min.

9. Birthplace N. Y. (City, county, and state)
10. Usual Occupation Professor of History
11. Industry or business Teaching

FATHER 12. Name Newton Curtis
13. Birthplace Maine

MOTHER 14. Maiden Name Gertrude Fordhamme
15. Birthplace N. Y.

16 (a) Informant Mrs. Blanche O. Curtis
(b) Address 4323 Wickford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 22/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Balto. Co. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 19 44, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 19 44, to 4-20 19 44, and that I last saw him alive on 4-20 19 44

Immediate cause of death: Coronary occlusion — Duration

Due to: Coronary sclerosis

Due to:

Other Conditions: Benign prostatic hypertrophy (Include pregnancy within 3 months of death)

Date of operation 4-17-44

Major findings of operation: Benign Prostatic hypertrophy

of autopsy: Coronary occlusion

PHYSICIAN Underline the cause to which it is thought should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Rogers
Address Univ. Hosp. Date signed 4/20/44

G 16435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G 16435

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 12hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 West Lee St (If rural give location)
(e) Citizen of foreign country? NO Yes or No? If yes, name country

3 (a) FULL NAME Baby Girl Temple "A"

3 (b) If veteran, name war NO | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife Infant

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 4/18/44

8. AGE: Years | Months | Days | If less than one day 12 hr. min.

9. Birthplace University Hosp (Town, county, and state)

10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Lottie Temple
15. Birthplace ?

16 (a) Informant Lottie Temple
(b) Address 624 West Lee St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL APR 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 22 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19/44 19 , at 12.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18/ 19 44 to 4/19 19 44 and that I last saw h alive on 4/19/ 19 44

Immediate cause of death Prematurity — Duration

Due to Failure of Development

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Rattle M.D.
M. D.
Address University Hosp Date signed 4/19/44

VS 150

0859

G 16436

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16436 Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Harman Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-3
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Harman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elda. M. Runkles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/12/44

8. AGE: Years	Months	Days	If less than one day
—	1	8	hr. min.

9. Birthplace Baltimore md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James. E. Runkles
13. Birthplace Baltimore md.

MOTHER
14. Maiden Name Othea Estep
15. Birthplace Baltimore Md.

16 (a) Informant Pearl Estep
(b) Address 1705 Harman Ave.

17 (a) Burial (b) Date thereof 4/22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cemetery
Location Washington Blvd.

18 (a) Funeral director Ambrose Inc
(b) Address 414 N Franklintown Rd

19 (a) APR 22 1944 Huntington Williams, M.D.
(Date received by Registrar) (Address)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 - 1944, at 5:57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1944, to April 20 - 1944, and that I last saw her alive on April 20 - 1944.

Immediate cause of death Bronchial Pneumonia — Duration unknown

Due to

Due to

Other Conditions Pleurisy — unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clinton Piland, M. D.
Address 2532 Edmondson Ave Date signed 4-21-44

G 16437.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16437. Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Howard & Madison

(c) Hospital or institution: Md. Gen. Hosp.

(d) Length of stay in hospital or inst. (~~years~~, months or days) 21 19-3

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)

(d) Street No. 1332 W. Lombard St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs. Louise Ollie Schmidt

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Harry A Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1890

8. AGE: Years 54 | Months 7 | Days 19 | If less than one day: hr min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name William Schide

13. Birthplace Balto Md

MOTHER 14. Maiden Name Genevere Van Dauker

15. Birthplace Balto Md

16 (a) Informant Mr. Donald Schmidt

(b) Address 1332 W Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Geo. L. Beyer Jr

(b) Address 1512 Hollins St

19 (a) (Date rec'd by registrar) (b) Registrar

APR 22 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944 at 1230 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1944 to April 21 1944, and that I last saw h~~e~~r alive on April 20 1944.

Immediate cause of death: Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. K. Williams M. D.

Address Md. Gen. Hosp. Date signed 4-21-44

C 16438

FAYA

BALTIMORE CITY HEALTH DEPARTMENT X 937

CERTIFICATE OF DEATH

G 16438 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harlem Ave
(c) Hospital or institution: St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Harlem Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Harry Faya

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Viola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/12/1882

8. AGE: Years	Months	Days	If less than one day
61	9	8	hr. min

9. Birthplace Maryland (State, county, and city)
10. Usual Occupation Retired Contractor
11. Industry or business

FATHER
12. Name Herman Faya
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Hoffman
15. Birthplace Maryland

16 (a) Informant Viola Faya
(b) Address 607 Harlem Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/44 (Month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Balto

18 (a) Funeral director Lloyd MacNabb
(b) Address Catonsville Md

APR 22 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1944, to April 20 1944, and that I last saw h[illegible] alive on April 19 1944.

Immediate cause of death Arteriosclerotic C-V-D

Duration

Due to

Due to

Other Conditions Bronchial Asthma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur Rosberg M.D.
Address St. Agnes Hosp. Date signed 4/20/44

G 16439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G 16439 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1832 Division Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore-17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 Division Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isabelle Thornton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	A.A.	single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/69

8. AGE: Years	Months	Days	If less than one day
75 75	0	2726	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unk
13. Birthplace

MOTHER
14. Maiden Name unk
15. Birthplace

16 (a) Informant Robert Tasker
(b) Address 1832 Division Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location md

18 (a) Funeral director Hugo H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date received) APR 22 1944 (b) Registrar's signature Wilmington, Del.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1944 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1944 to 4/20 1944 and that I last saw h[illegible] alive on 4/20 1944.

Immediate cause of death Cardiovascular Renal Disease — Duration 34 Days
Due to senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carson C. Johnson M. D.
Address 1802 Penna Ave Date signed 4/21/44

G 16440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16440 Registered No. 12B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Roland & Thorn
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Fairmount (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

4 2

3 (a) FULL NAME Wilbur Peyton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years	Months	Days	If less than one day
22	0		hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Dishwasher

11. Industry or business

FATHER
12. Name Ralph Peyton
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Sams
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof April 26 44 (month) (day) (year)
(c) Cemetery or crematory Salunga
Location Middlesex, Va.

18 (a) Funeral director Geo. D. Kelson
(b) Address 303 Prentiss St

19 (a) (b) Registrar
Dec'd Dec'd 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1944, at 5 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-13 1944 to 4-19-1944, and that I last saw him alive on 4-19-1944.

Immediate cause of death	Duration
Mediastinal Emphysema	30 min.
Due to Tuberculous pneumonia	6 days
Due to Pulmonary tuberculosis	?
Other Conditions Pleural effusion - type Pneumothorax - at.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: Miliary pulmonary tbc.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. O. Palmer M. D.
Address University Hospital Date signed 4/22/44

G 16441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16441 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 N.Pat.Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 N.Pat.Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Miller

3 (b) If veteran, name war ----
3 (c) Social Security Account No. -----

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.12,1867

8. AGE: Years 77 | Months 1 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Balto.Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Laura----
15. Birthplace Germany

16 (a) Informant Mrs.Huber
(b) Address 907 N.Pat.Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr.24/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto.Md.

18 (a) Funeral director Philip Stewart Sons
(b) Address 2024 Orleans St.
(c) Date rec'd by registrar APR 22 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr.20/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 19 44 to April 20 19 44 and that I last saw him alive on April 19 19 44.

Immediate cause of death: Bronchopneumonia — Duration: 4 days
Due to: Chronic Myocarditis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Russell B. Wolfe M. D.
1331 E. Lanvale
Address
Date signed 4-21-44

G 16442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1106

Registered No. G 16442

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 N Bruce St
(c) Hospital or institution: Balto md 1944
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Dollers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Beatrice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-6-1912

8. AGE: Years 31 Months 9 Days 14 If less than one day hr. min.

9. Birthplace Balto. md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Clement Dollers
13. Birthplace Md.

MOTHER
14. Maiden Name Ceva Kent
15. Birthplace Md.

16 (a) Informant Mrs Ceva Dollers
(b) Address 25 N Bonner St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location Arbutus, Md

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Dakota Ave St.

APR 22 1944 (Date filed by registrar) Huntingtown Williamsport Md

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to April 20 1944, and that I last saw h l alive on April 20 1944.

Immediate cause of death

Due to (a) Pulmonary Tuberculosis Non-Tuber

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph W. Rattling
Address 424 N. Gilmor Date signed April 22 1944

G 16443

MA - 80866

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

G 16443

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

16-3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Gary

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25-1869

8. AGE: Years	Months	Days	If less than one day
74	10	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Gary
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Boswell
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 22 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

A

20. DATE OF DEATH April 21 1944, at 8.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1943 to 4-21 1944
and that I last saw h[illegible] alive on 4 21 1944.

Immediate cause of death
Pneumonia
Duration 5 days

Due to Hypostatic congestion
Coronary thrombosis

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: No about

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul McBee M. D.
Address B. C. H. Date signed 4/24/44

G 16444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G 16444

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1822 N Monroe St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM-EDWARD-CRANDOL

3 (b) If veteran, name war none

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Daisy May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12. 1878

8. AGE: Years 65 | Months 6 | Days 8 | If less than one day: hr. min.

9. Birthplace Bethel, Va. (Town, county, and state)

10. Usual Occupation Tool Maker - Retired

11. Industry or business B. & O. R. R.

FATHER
12. Name Thomas J. Crandol
13. Birthplace Va.

MOTHER
14. Maiden Name Eleanor Lucas
15. Birthplace Va.

16 (a) Informant Mrs. Daisy May Crandol
(b) Address 1822 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 4/24/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 22 1944 (Date rec'd by registrar)

19 (a) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944 at 5 33 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1944 to 4-20 1944, and that I last saw him alive on 4-20 1944.

Immediate cause of death acute pulmonary edema — **Duration**

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M. D.
Address West. Balto. Gen. Hosp. Date signed 4/20/44

VS 180

Duke Checked by M.E.

G 16445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16445

JL - 87869

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3107 N. Calvert St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ella Virginia Downing

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	F	W	Widowed

6 (b) Name of husband or wife Joseph F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1860

8. AGE: Years	Months	Days	If less than one day
83	11	12	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name John Robertson

13. Birthplace Md.

MOTHER 14. Maiden Name Margaret White

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) 4 22 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 19 44, to 4-21 19 44, and that I last saw her alive on 4-21 19 44.

Immediate cause of death — Duration

Bronchopneumonia

Due to Hypostasis

Due to Hypostatic congestion & Edema

Other Conditions Intertrochanteric fracture Rt femur

(Include pregnancy within 3 months of death)

Date of operation 4-5-44

Major findings of operation: Tack applied

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: 2/2

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 3-27-44 at 7 P.M.

(c) Where did injury occur? Balto City 3107 N. Calvert St. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Accidental fall in bathroom

23. Signature Donald F. Webb M.D.

Address Balt City Hosp. Date signed 4-21-44

For R. W. L. Mallonnee, by Howard J. Mackey M.D.

G 16446

L. Johnson Jan 16446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1310

Registered No. 16446

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 E. 25rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 E. 25rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reginal B. Roberts
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/5/1896

8. AGE: Years	Months	Days	If less than one day
48 49	-	15	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Roberts
13. Birthplace Va

MOTHER
14. Maiden Name Fannie B. Coker
15. Birthplace Va

16 (a) Informant James M. Coker
(b) Address Pen Hotel

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

(a) APR 22 1944 (Date rec'd by registrar) (b) Huntington Mills Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 20 1944 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1944 to Apr 20 1944 and that I last saw h alive on Apr 20 1944

Immediate cause of death Cardio - Renal Disease — Duration 6 mos
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Louis A. Johnson M.D.
Address 2329 Guilford Ave Date signed Apr 22 1944

G 16447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B Registered No. G 16447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 2 - 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 S. Broadway Balt 31 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Bystry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-1-107

8. AGE: Years	Months	Days	If less than one day
36	9	16	18 hr 40 min.

9. Birthplace Balt. Maryland (Town, county, and state)
10. Usual Occupation Laborer - Unemployed
11. Industry or business

FATHER
12. Name Mathew Bystry
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Agnes Drangch
15. Birthplace Poland

16 (a) Informant Mrs Josephine Ruszkiewicz
(b) Address 869 S. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto County

18 (a) Funeral director John M. Wilbur
(b) Address 404 S. Chester Street

19 APR 22 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20- 1944 at 6 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1944 to 4-20 1944, and that I last saw him alive on 4-20 1944.

Immediate cause of death Cardiac Failure.
Duration 19 days

Due to Rheumatic Heart Disease.
29 years

Due to

Other Conditions Pulmonary Edema - anasarca
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul R. Ziegler M. D.
Address Mercy Hospital Date signed 4-20-44

G 16448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G 16448 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 4/8/44
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 St. Paul Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME HENRY LEE YOUNG

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/22/1860

8. AGE: Years	Months	Days	If less than one day
83	6	0 2 9	hr. min.

9. Birthplace Harford County, Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name William Young
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Elizabeth Cochran
15. Birthplace Harford Co., Md.

16 (a) Informant Records, U. S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 22/44 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Emmorton Harford Co Md

18 (a) Funeral director Deaver & Foster
(b) Address Bel Air, Md

19 APR 22 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1944, at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 8, 1944, to Apr. 21, 1944, and that I last saw him alive on Apr. 21, 1944.

Immediate cause of death	Duration
Bronchopneumonia	Terminal
Due to Sweat gland adenocarcinoma (colloid skin of right scrotum) with associated Paget's disease CHECK of surrounding skin and metastasis to area femoral, inguinal and illa nodes.	4 yrs.
Other Conditions Generalized arteriosclerosis	Unk.

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Stern M. D.
Address Baltimore, Md. Date signed 4/22/44

VS 150

File #52202

C 16449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

✓ C 16449 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West. Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Lee Stockman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-40

8. AGE: Years	Months	Days	If less than one day hr.	min.
		7		

9. Birthplace West. Balt. Gen. Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Franklin H. Stockman
13. Birthplace Md.

MOTHER
14. Maiden Name Dorothy E Bauserbach
15. Birthplace Pa.

16 (a) Informant Franklin H Stockman
(b) Address 1100 E 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden

18 (a) Funeral director L. Hansmann & Son
(b) Address 3615-17 Labyrinth Ave.

19 (a) APR 23 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1944 to April 22 1944, and that I last saw her alive on April 22 1944.

Immediate cause of death

Asthenia Pneumonia

Due to Lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. N. Friedman
Address West Balt Gen Hosp Date signed 4/23/44

G 16450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c

G 16450 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 2/16/1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since 2/16/1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1946 W. Franklin Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ARTHUR JOSEPH PALLISSARD

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna Thalheimer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 20, 1894
8. AGE: Years 49 | Months 23 4 | Days 1 | If less than one day ... hr. ... min.
9. Birthplace Kaukakee, Ill. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Merchant Marine

FATHER
12. Name Alfred M. Pallissard
13. Birthplace France

MOTHER
14. Maiden Name Marine Grandpre
15. Birthplace Ill.

16 (a) Informant Records, U. S. Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-44 (month) (day) (year)
(c) Cemetery or crematory Bell's Nath Cem. Location Frederick Ave.

18 (a) Funeral director A. Lee Odea
(b) Address 7644 York Road Towson, Md.

APR 23 1944

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS 130

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Apr. 21, 1944, at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16, 1944 to Apr. 21, 1944, and that I last saw him alive on Apr. 21, 1944.

Immediate cause of death: Diffuse bronchial pneumonia, lower lobe left lung — Duration: 1 week

Due to: Squamous cell carcinoma mouth & right cheek — 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. S. Bra...
Address Baltimore, Md. Date signed 4/21/44

MS-51053

C 16451

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 16451 Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct and complete. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4910 Chalgrove Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agostino G. Vinci

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Grace Vinci
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul 22 1883

8. AGE: Years	Months	Days	If less than one day
60	8	29	hr. min.

9. Birthplace Cefalu Italy (Town, county, and state)
10. Usual Occupation Shoemaker (Retired)
11. Industry or business

FATHER
12. Name Attanasio Vinci
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Rosso
15. Birthplace Italy

16 (a) Informant Anna J. Giulio (Daughter)
(b) Address 4912 Chalgrove Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24/44 (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~ New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

23 1944
VS

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944 at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1944 to April 20 1944 and that I last saw him alive on April 20 1944

Immediate cause of death Cerebral Hemorrhage - Duration hours

Due to Hypertension years

Due to Arteriosclerosis - years

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. J. Guard M. D.
Address Medical Arts Bldg. Date signed

G 16452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16452
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, if available. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S. C. (b) County
(c) City or town Bennettsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward McCall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Sarah Ella Dubose
(b) Address Hamlet, N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)
(c) Cemetery or crematory Hamlet
Location North Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) APR 23 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1944, at 11:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphiletic aortitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. E. Wollam Jr. M.D.
Medical Examiner.
Date signed April 21, 1944.

G 16453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 16453 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd and Calvert St.

(c) Hospital or institution: Union Memorial Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3041 Cranmart Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Lynn Bauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/2/44

8. AGE: Years | Months | Days 22 | If less than one day: hr. min. 20

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Carl H. Bauer

13. Birthplace Indiana

MOTHER

14. Maiden Name Margaret K. Hayes

15. Birthplace Pennsylvania

16 (a) Informant CARL H. BAUER

(b) Address 3021 CRESMONT AV

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 4/22/44 (month) (day) (year)

(c) Cemetery or crematory WARREN, PENNA

Location

18 (a) Funeral director CHAS. E. EVANS & SON

(b) Address 118 W Mt. Royal AVENUE

19 (a) Date received APR 23 1944 (Registrar) (b) Registrar Huntington Williams M.D.

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1944 to April 22 1944 and that I last saw h CR alive on April 22 1944

Immediate cause of death Cardio Respiratory failure — Duration

Due to Multiple abscess of left lung

Due to Atelectasis of left lung

Other Conditions Lobar Pneumonia Rt. lung

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Multiple abscess L. Lung

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hurl Bowers M.D.

Address Union Memorial Hospital

Date signed 4/22/44 M. D.

452748 G 16454 — BALTIMORE CITY HEALTH DEPARTMENT — G 16454 Registered No.

CERTIFICATE OF DEATH

5 6 E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C (b) County
(c) City or town SWANNANOA (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK Allen JR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-21-30

8. AGE: Years	Months	Days	If less than one day hr.	min.
13	11	1		

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name FRANK Allen
13. Birthplace NC
14. Maiden Name MARY Foster
15. Birthplace N.C

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Piney Grove
Location Swannanoa N. C.

18 (a) Funeral director John O. Mitchell + Sons Inc.
(b) Address 200 Eutaw Place

19 (a) APR 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 22 1944, at 6 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 17 1944, to Apr 22 1944, and that I last saw him alive on Apr 22 1944.

Immediate cause of death	Duration
(a) Appendicitis, ruptured	
Due to (b) Operative complication	
Due to (c) Anuria	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/19, 4/20, 4/21

Major findings of operation: Appendicitis, ruptured. Local peritonitis

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Johns Hopkins Hosp Date signed 4/22/44

G 16455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16455 Registered No. 1248

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Montpelier St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lucas

3 (b) If veteran, name war

3 (c) Social Security Account No. 187-03-6429

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ina Lucas
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Apr. 6, 1885

8. AGE: Years	Months	Days	If less than one day
59	—	17	hr. min.

9. Birthplace Hazleton, Pa. (Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Ship Building

FATHER 12. Name	Pete Lilly
FATHER 13. Birthplace	Italy
MOTHER 14. Maiden Name	Unknown
MOTHER 15. Birthplace	

16 (a) Informant A. H. Lucas
(b) Address Hazleton, Pa.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-1944 (month) (day) (year)
(c) Cemetery or crematory Hazleton
Location Hazleton, Pa.
18 (a) Funeral director Andrew R. Sterr
(b) Address Hazleton, Pa.
19 (a) (Signature of registrar) Hunter Wm. Williams M.D.

APR 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1944, to 4/23 1944, and that I last saw ~~him~~ alive on 4/23 1944.

Immediate cause of death (a) Pulmonary Edema — Duration

Due to (b) Lobar Pneumonia

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Walkup M. D.
Address 1400 N. Caroline St. Date signed 4/25/44

H. E. WALKUP

G 16456

G 16456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G 16456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 George St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 1
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 George St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Allen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-1-1879

8. AGE: Years 64 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Richard Allen

13. Birthplace N. C.

MOTHER 14. Maiden Name Emma Jones

15. Birthplace N. C.

16 (a) Informant Cassie Allen

(b) Address 722 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Penna ave

APR 23 1944 (a) (Registrar) (b)

Huntington-Williamsport, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944, at 7.9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1944 to 4/21 1944 and that I last saw him alive on 4/21/1944.

Immediate cause of death Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 6 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 7 W Green Date signed 4-22-44

G 16452 ✓ G 16452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful, supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Baker st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Baker st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E Smith
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Junior
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 12-16-1883
8. AGE: Years 60 | Months 4 | Days 4 | If less than one day hr. min.
9. Birthplace Tennessee (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant J. S. Wiggins
(b) Address 507 Baker St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md
18 (a) Funeral director Mulligan & Jackson
(b) Address 916 Penna ave.
(c) (b)

APR 23 1944
(Date rec'd by registrar)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1944, at 7 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from April 5 1944 to April 20 1944 and that I last saw him alive on April 21 1944.

Immediate cause of death
Carcinoma of the Breast
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration Hrs. Days Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Gaylord Howell, M. D.
Address 1534 Druid Hill Ave Date signed 4-22-44

G 16458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16458

45c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 932 W. University Pkwy (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clifford Cornelson

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Meta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE Years	Months	Days	If less than one day hr.	min.
67				

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation Broker
11. Industry or business

FATHER
12. Name Jacob Cornelson
13. Birthplace N. Y.

MOTHER
14. Maiden Name Randolph
15. Birthplace Va.

16 (a) Informant Mrs. E.S. Cornelson
(b) Address 932 W. Univ. Pkwy

17 (a) Removal & Burial (b) Date thereof 4-23-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Martinsburg
Location Martinsburg W Va.

18 (a) Funeral director H. L. Wiginborhony
(b) Address Ellicott City Md

19 (a) (Date received by registrar) (b) Registrar

APR 23 1944 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 19 44 at 6 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 19 44 to 4-23 19 44, and that I last saw h[illegible] alive on 4-23 19 44

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to Carcinoma 2 months Arteriosclerotic heart dis	
Other Conditions Senility prostatic hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation 4-18-44

Major findings of operation: Senile prostatic hypertrophy

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work) (Specify type of place)
(e) Means of injury

23. Signature C. Sal Ingram M. D.
Address Sinai Hospital Date signed 4-23-44

G 16459 ✓ G 16459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4217 Old Frederick Rd
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4217 Old Frederick Rd
(If rural give location)
(e) Citizen of foreign country? Yes or No:
If yes, name country

3 (a) FULL NAME Mary Doherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Thomas J. Doherty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11 1872

8. AGE: Years	Months	Days	If less than one day hr.	min
71	5	11		

9. Birthplace Cleveland Ohio
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business At home

FATHER
12. Name Martin Rawley
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine O'Toole
15. Birthplace Ireland

16 (a) Informant Mrs Charles E Porter
(b) Address 4219 Old Frederick Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/24/44 (month) (day) (year)
(c) ~~Cemetery or crematory~~ New Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) [illegible] (b) Huntington Williams, M.D.

APR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1944, at 4 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to April 21 1944, and that I last saw her alive on April 21 1944

Immediate cause of death Carcinoma of Liver — Duration 18 Mo.

Due to

Due to

Other Conditions Uremia Hemorrhage Arteriosclerosis Senile.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel L Hopkinson M.D.

Address 5028 Park Ave, Date signed 4/24/44

WW 150

G 16460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16460 Registered No. 927

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Curtis Bay Sodom
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1005 Redmon Way (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J Hopkins

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 161-09-4960

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Monahe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7, 1878

8. AGE: Years 65 | Months 5 | Days 15 | If less than one day: hr. min.

9. Birthplace Toronto Ca (Town, county, and state)

10. Usual Occupation Carpet Room Retired

11. Industry or business

FATHER
12. Name Patrick Hopkins
13. Birthplace Ireland

MOTHER
14. Maiden Name Mahoney
15. Birthplace Ca

16 (a) Informant Charles Hopkins
(b) Address 1005 Redmon Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1319 E Fort Ave

19 (a) (Date received) (b) Registrar Huntington Williams M.D.

APR 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 16 1944, to April 22 1944, and that I last saw h/m alive on April 22 1944.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A Lasker M. D.
Address 1213 Light Street Date signed Apr 22 1944

G 1646I

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

G 1646I Registered No.

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 4/6/44
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk 22nd Ward
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Charlotte Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST JILES

3 (b) If veteran, name war -

3 (c) Social Security Account No. 231-01-3466

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife: Pearl Hale (Deceased)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/22/1895

8. AGE: Years 49 | Months 2 | Days 28 | If less than one day: hr. min.

9. Birthplace Newport News, Va.
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Merchant Marine

FATHER
12. Name Thomas Jiles
13. Birthplace Houston, Texas

MOTHER
14. Maiden Name Mary Martha ?
15. Birthplace Vermont, Texas

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md

18 (a) Funeral director Isaiah L. Burns & Son
(b) Address 108 W Montgomery St

19 (a) Filed APR 23 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Apr. 19, 1944, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 6, 1944, to Apr. 19, 1944, and that I last saw h. im alive on Apr. 19, 1944

Immediate cause of death: Syphilitic aortitis with rupture of aneurysm into upper lobe of left lung — Duration: Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. S. Bladen M. D.

Address Baltimore, Md. Date signed 4/20/44

MS-52177

G 16462 G 16462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: Sinai Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3606 Liberty Heights Ave (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Louis Shapiro

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Fanne

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb, 15, 1872

8. AGE: Years 72 Months 2 Days 8 If less than one day hr. ..... min. .....

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation .....

11. Industry or business Retired

FATHER 12. Name David Shapiro

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Unkown

MOTHER 15. Birthplace Russia

16 (a) Informant Frank Shapiro

(b) Address 3 606 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April. 23, (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cemetery

Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

19 (a) Huntington Williams M.D. (Date rec'd by registrar)

APR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23/44 19 ..... at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21/1944 to 4/23/1944 and that I last saw him alive on 4/23/1944.

Immediate cause of death Pulmonary edema — Duration .....

Due to Arteriosclerotic & hypertensive heart disease .....

Due to ....

Other Conditions Diabetes Mellitus .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) 1944 of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Murray Lerner M. D.

Address Sinai Hosp. Date signed 4/23/44

G 16463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 16463

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address I843 W. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1843 W North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Sonner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Leah K.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
78 77			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Harry Sonner
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Mrs Edith Steinberg
(b) Address I843 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) [illegible] (b) [illegible]

APR 23 1944 Huntington Williams, M.D. Registrar

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944 at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1938. to April 21st 1944.
and that I last saw him alive on April 21st 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 2 hours

Due to Cerebral arterio-sclerosis and hypertension — 6 years

Due to old age

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Pushkin M. D.
Address 2338 Eutaw pl. Date signed 4-24-44

G 16464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16464 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 15 E of Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore st (If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 Park Heights ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE PEARL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day hr.	min.
65				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Housework

FATHER
12. Name Mendel Poliakoff
13. Birthplace Russia

MOTHER
14. Maiden Name Baila Poliakoff
15. Birthplace Russia

16 (a) Informant Rabbi J. Poliakoff
(b) Address 3410 Pk Heights ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosedale Cemetery
Location Hamilton ave

18 (a) Funeral director Sol Levenson Bro
(b) Address 1124-26 W Northern ave

19 (a) (Date received by registrar) Huntington Williams M.D.

APR 23 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1944, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1944, to 4/22 1944, and that I last saw h[illegible] alive on 4/22 1944.

Immediate cause of death Carcinomatosis

Due to Ca of Pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb. 1943

Major findings of operation Ca of Head of Pancreas

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lemuel E Nicholas M. D.
Address Sinai Hosp. Date signed 4/24/44

G 16465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12112

G 16465

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. yrs., mos., or days 6 days
(e) Length of stay in Baltimore yrs. mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 Herkimer St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Stanley Sliakis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Vivian Sliakis
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. May 22, 1908

8. AGE: Years	Months	Days	If less than one day
35	10	28	hr min

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Adam Sliakis
13. Birthplace Lithuania

MOTHER
14. Maiden Name Anna Remacus
15. Birthplace Lithuania

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John A. Szebiankowski Jr
(b) Address 423 S. Paca St.

19 Date received by registrar APR 23 1944 Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14 1944, to 4/20 1944, and that I last saw him alive on 4/20 1944

Immediate cause of death Uremia; Bronchopneumonia, Bilateral empyema, Bilateral
Due to
Due to
Other Conditions Hepato-renal syndrome
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post.

Duration: ?

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seligman
Address BCH Date signed 4/20

G 16466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G 16466 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & CALVERT
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 N. Payson St. (If rural give location)
(e) Citizen of foreign country? If yes, name country — Yes or No

3 (a) FULL NAME MR. Benjamin Sacks
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Jewish
6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Mrs. Jennie Sacks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1887

8. AGE: Years 57 | Months 5 | Days 6 | If less than one day: hr. min

9. Birthplace EUROPE (Town, county and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Isaac Sacks
13. Birthplace Europe

MOTHER
14. Maiden Name Leba ?
15. Birthplace Europe

16 (a) Informant JENNIE SACKS
(b) Address 1804 N. PAYSON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-23-44 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL RD + HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST.

APR 23 1944

(b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22 1944 at 12 15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-27 1944 to 4-22 1944 and that I last saw h IM alive on 4-22 1944

Immediate cause of death CARDIO-RESP. FAILURE — Duration

Due to ARTERIOSCLEROTIC HEART DISEASE

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the one to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Van Lill III M.D.
Address Union Memorial Hosp. Date signed 4-22-44

G 16467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G 16467

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4113 BELVIEW AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:

a. State MD. b. County

c. City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

d. Street No. 4113 BELVIEW AVE (If rural give location)

e. Citizen of foreign country? Yes or No?

If yes, name country

3 (a) FULL NAME JOSEPH M. BRANSKY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife REBECCA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) IX 1 2

8. AGE: Years	Months	Days	If less than one day
72			hr min.

9. Birthplace RUSSIA (Town, county and state)

10. Usual Occupation RETIRED MERCHANT

11. Industry or business

FATHER

12. Name AARON BRANSKY

13. Birthplace RUSSIA

MOTHER

14. Maiden Name BESSIE

15. Birthplace RUSSIA

16 (a) Informant REBECCA BRANSKY

(b) Address 4113 BELVIEW AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof (month) (day)

(c) Cemetery or crematory ~~Mount Lebanon~~ OHEB SHOLEM CEM.

Location

18 (a) Funeral director JACK LEWIS INC

(b) Address 1439 E. BALTO. ST.

19 (a) (Signature of registrar) (b) Registrar

APR 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21-44 19 . at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 43 to April 21, 1944.

and that I last saw h alive on April 21, 19 44

Immediate cause of death Acute cardiac dilatation — **Duration**

Due to

Due to Lobar Pneumonia — 7 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Sidney J. Levy

Address 2322 Eutaw Place Date signed 4/25/44

G 16468

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 15

G 16468 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 N. Pearl Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N. Pearl Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel A Gibilisco

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 2 - 1917

8. AGE: Years	Months	Days	If less than one day
30	3	19	hr min

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sabastiano Gibilisco
13. Birthplace Italy

MOTHER
14. Maiden Name Marieta Serio
15. Birthplace Italy

16 (a) Informant Joseph Mascari
(b) Address 8 N Luzerne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24-1944 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Belair Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Greenmount Ave.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

APR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21- 1944 at Na M

21. I certify that death occurred on the date above stated, that I attended deceased from 2-20 1944 to 4-21 1944 and that I last saw h alive on 4-20 1944

Immediate cause of death Shock -

Duration hours ? days ? weeks ? years

Due to abdominal abcess 10 days

Due to Peritoneal tuberculosis -

Other Conditions operated on at U of M. hospital

(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operation: T-B - Peritonitis -

of autopsy: no -

PHYSICIAN (Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Medical Arts Bldg Date signed

G 16469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 937

G 16469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1719 No Payson St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Hogrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give location)

(d) Street No. 1719 No Payson St (If rural give location)

(e) Citizen of foreign country? (Yes or No) Yes

If yes, name country

3 (a) FULL NAME Rubin Whitten

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1567

8. AGE: Years 77 Months Days If less than one day hr min

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Simon

13. Birthplace Russia

MOTHER 14. Maiden Name Hannah

15. Birthplace Russia

16 (a) Informant Mrs. Meyerhoff

(b) Address Murray Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Memorial Park

Location

18 (a) Funeral director Jack Pearlman Inc

(b) Address 1439 E. Baltimore St

APR 23 1944

(Date received by registrar) (b) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20- 1944 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1944 to 4/23 1944, and that I last saw h[illegible] alive on 4/23 1944

Immediate cause of death Pneumonia — Duration 7 days

Due to

Due to Arteriosclerosis — 11 yrs

Other Conditions Hypertension Chronic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W J Bayless

Address 2040 Eutaw Date signed 4/24

G 16470

G 16470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 649 West Mulberry St (If rural give location)
(e) Citizen of foreign country? NO Yes or No
If yes, name country

3 (a) FULL NAME William Lee Kennedy

3 (b) If veteran, name war Infant

3 (c) Social Security Account No. Infant

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Infant

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 13 1943

8. AGE: Years | Months 4½ | Days 9 | If less than one day: hr | mm

9 Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Wade Kennedy
13. Birthplace South Carolina

MOTHER
14. Maiden Name Sarah Kennedy
15. Birthplace Knox Carolina

16 (a) Informant Wade Kennedy
(b) Address 649 W. Mulberry St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/24-44 (month, day, year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 (a) (Date received by registrar) (b) Registrar

APR 23 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1944, at 9⁰⁵ A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from April 1 1944, to April 22 1944, and that I last saw him alive on 4/22 1944

Immediate cause of death Respiratory failure — **Duration**

Due to Atelectasis

Due to Possible Pyloric Stenosis

Other Conditions A Congenital Deformity B GI Tract

(Conditions contributing but not related to cause given in 21)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
23. Signature Cliff Rulette, Jr.
Address Univ Hosp Date signed 4/22/44 (M.D.)

G 16471 BALTIMORE CITY HEALTH DEPARTMENT G 16471

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N.PATTERSON PARK.AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 10 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL, and give town)
(d) Street No. 100 N.PATTERSON PARK AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY L.TARBELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife MATTHEW M.TARBELL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT.5 1857

8. AGE: Years	Months	Days	If less than one day
86	7	16	hr. min.

9. Birthplace ALBANY NY. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT.HOME

FATHER
12. Name ? FOWLER
13. Birthplace NY.

MOTHER
14. Maiden Name ? TOWNLEY
15. Birthplace NY.

16 (a) Informant FREDERICK GOEB.
(b) Address 100 N.PATTERSON PARK AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR.24/44 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEM.
Location END OF EAST NORTH AVE.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S.WOLFE ST.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

APR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH APR.21 1944, at 3/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 19XX to Apr 21 19XX and that I last saw h[illegible] alive on Apr 20 19XX.

Immediate cause of death Senile cardio vascular renal disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. D. Lyon M. D.
Address 3/30 N Patterson Pk Date signed 4/22/XX

G 16472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 152

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1339 Hull St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jack L. Marren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-12-44

8. AGE: Years	Months	Days	If less than one day
		12 10	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack Marren
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elvira Loose
15. Birthplace Baltimore

16 (a) Informant Carrie Loose
(b) Address 1339 Hull St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location [redacted]

18 (a) Funeral director Charles R. Dill
(b) Address 1521 E. Fort Ave

19 (a) (b) Registered by registrar Huntington Williams M.D. Registrar

APR 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 20 1944, to Apr. 22 1944, and that I last saw him alive on Apr. 22 1944.

Immediate cause of death Septicemia — Duration

Due to Cellulitis of left leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Apr. 20 1944
Major findings of operation: Cellulitis of left leg
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H. Lukat M. D.
Address 1213 Light St Date signed Apr. 22 1944

G 16473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G 16473

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. See correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lund Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Annabel Ave. (If rural give location) Brooklyn Md
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice S. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-2059

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1878

8. AGE: Years 66 | Months - | Days 10 | If less than one day hr. min.

9. Birthplace Lewiston Pa (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Samuel H Snyder
13. Birthplace Pa

MOTHER
14. Maiden Name Sarah A Lyter
15. Birthplace Pa

16 (a) Informant Mrs Mildred Pearman
(b) Address 535 Annabel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery or crematory Woodland Mem Cem.
Location Taylor Ave

18 (a) Funeral director William M Marsch
(b) Address 715 E. Lexington St.

19 (a) APR 23 1944 (Registrar) Huntington Williams M.D. Registrar

VR 161

MEDICAL CERTIFICATION 25

20. DATE OF DEATH April 20, 1944 at 9 A M

21. I certify that I took charge of the remains described above, held an Inspection & Enquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were,

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Lyter M.D. Medical Examiner.

Date signed 4/24/44

G 16474 BALTIMORE CITY HEALTH DEPARTMENT G 16474
Registered No.

CERTIFICATE OF DEATH 12/a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Meehan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Violette D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1872

8. AGE: Years	Months	Days	If less than one day
71	11	24	hr. min

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Advertisement (owner)
11. Industry or business

FATHER
12. Name Patrick Meehan
13. Birthplace Ireland

MOTHER
14. Maiden Name Theresa Farley
15. Birthplace Ireland

16 (a) Informant Mrs Violette D. Meehan
(b) Address 3010 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Leonard J. Post
(b) Address 3305 Harford Road

19 (a) Local registrar (b) Date received APR 23 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21-1944 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16-1944 to 4-21-1944, and that I last saw him alive on 4-21-1944.

Immediate cause of death	Duration
Arteriosclerosis cardio-renal disease	Unknown
Due to	
Due to	
Other Conditions Duodenal ulcer	Unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury

23. Signature Geo. B. Lybert M. D.
Address 2802 Harford Rd Date signed 4-22-44

G 16475 X G 16475

452392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 121a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town Pittsburgh (If outside city or town limits write RURAL and give town)
(d) Street No. 4030 CentreAve Hadden Hall Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sudie Summers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John P. Summers
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 10-15-98

8. AGE: Years	Months	Days	If less than one day
45	6	8	hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business At Home

FATHER
12. Name J.T. McCannell
13. Birthplace VA.

MOTHER
14. Maiden Name Mattie Hicks
15. Birthplace TENN.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4 23 44 (month) (day) (year)
(c) Cemetery or crematory Gate City
Location Virginia

18 (a) Funeral director William Cook Inc
(b) Address St Paul St

APR 24 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23rd 1944, at 9 M

21. I certify that death occurred on the date above stated; that attended deceased from 4/12/ 1944 to 4/23/ 1944
and that I last saw h alive on 4/23/ 1944,

Immediate cause of death Terminal uremia — Duration 5 days

Due to nephrosclerosis — 1 yrs.

Due to Hypertensive vascular disease, generalized arteriosclerosis — 2 yrs.

Other Conditions Pyelonephritis, acute C.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Dublin M.D.
Address Johns Hopkins Hosp Date signed 4/23

VS 250

G 16476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 16476 / 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Warren Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Timoney

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892 ?

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Pima (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Patrick F Timoney
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Penny
15. Birthplace Ireland

16 (a) Informant Wahl Funeral Service
(b) Address Scranton Pima

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Scranton Pa

18 (a) Funeral director George G Farley
(b) Address Scranton Pa

19 APR 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944, at 5 30 P.M.

21. I certify that I took charge of the remains described above, held an Inquisition (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial pneumonia; emphysema, left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed April 23 1944

G 16477

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G 16477 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4930 Litchfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Sinsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Saaed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 43 | Months | Days | If less than one day: hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER
12. Name Mayer Kreaser
13. Birthplace Russia
14. Maiden Name Gkele
15. Birthplace Russia

16 (a) Informant Hyman Gerade
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-44 (month) (day) (year)
(c) Cemetery or crematory Nelson Funeral Home
Location Baltimore Garden Sts

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St

APR 24 1944 (Date rec'd by registrar) (b) Hunting to Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944, at 6.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1944, to April 23 1944, and that I last saw her alive on April 23 1944.

Immediate cause of death myocardial failure with pulmonary edema — Duration
Due to hypertensive cardiovascular disease
Due to malignant nephrosclerosis
Other Conditions uremia

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis G. Meiselas
Address Sinai Hosp Date signed 4/25

C 16478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C 16478 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring
(c) Hospital or institution:
Hebrew Home for Aged & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Feinstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Aged Home
(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4-24-44 (month) (day) (year)
(c) Cemetery or crematory Pikesville
Location Old Pikesville & Hamilton Ave
18 (a) Funeral director Jack Davidow
(b) Address 1439 E. Baltimore St. Hunting Ridge, Maryland
19 (a) APR 24 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1941, to 4-23 1944, and that I last saw h alive on 4-23 1944.

Immediate cause of death Hypertension, Arteriosclerosis Chr. card. vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edmund Levin M. D.
Address Levindale Date signed

G 164751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W Cumberland St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 The Alameda (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Annie Mary Hunter

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Albert
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1871

8. AGE: Years	Months	Days	If less than one day
73	2	22	hr ..... min.

9. Birthplace Pine Grove Furnace, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Grimes
13. Birthplace Pine Grove

MOTHER
14. Maiden Name Ellen Tuckey
15. Birthplace Hendersville, Pa.

16 (a) Informant Mr. Russell Marks
(b) Address Round Bay, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ..... (b) ..... (Signature and title of registrar) Hunting for Williams, M.D.

APR 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1944, to 4/21 1944, and that I last saw h.. alive on 4/21 1944.

Immediate cause of death Generalized Abdominal Carcinomatosis — Duration .....

Due to Carcinoma of Gall Bladder — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation 4/7/44

Major findings of operation: 4/7/44 Carcinoma site undetermined

of autopsy: Carcinoma of Gallbladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Mother M. Ramonite
Address St Joseph's Hosp. Date signed 4/21/44

G 16480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G 16480

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2913 Chelsa Terrace

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2913 Chelsa Terrace (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frances Claibourn Blankenship

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Rufus D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1875

8. AGE: Years	Months	Days	If less than one day
68	8	16	hr min.

9. Birthplace Winter Park Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name David James Claibourn

13. Birthplace Winter Park, Va.

MOTHER 14. Maiden Name Margaret Blankenship

15. Birthplace Va.

16 (a) Informant Mr. Earl C. Blankenship

(b) Address 2913 Chelsa Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 24-44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn - Md.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address North & Pa. Aves

19 (a) (Date rec'd by registrar) (b) Registrar

APR 26 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1944, at 7:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1943 to April 21 1944, and that I last saw her alive on 4/2/1944.

Immediate cause of death Pneumonia — Duration 1 day

Due to Coronary Thrombosis 4 days

Due to Arteriosclerosis years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Earl C. Blankenship M. D.

Address 3403 Garrison Blvd Date signed 4/26/44

To be filled by M.D.

G 16481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G 16481

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4713 Homer Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 18

(e) Length of stay in Baltimore (yrs., mos., or days) 19 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4713 Homer Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ERNEST R. CRAWFORD

3 (b) If veteran, name war	3 (c) Social Security Account No.
Yes	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1890

8. AGE: Years	Months	Days	If less than one day
54	2	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business P. R. R.

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace U

16 (a) Informant Mrs. Eva Irene Crawford

(b) Address 4713 Homer Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b)

(Date rec'd by registrar) Registrar

APR 23 1944

VS 150

Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from on 4-20 1944. Dead on arrival and that I last saw him alive on Made 1944

Immediate cause of death Coronary Thrombosis

Due to Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration Suddenly Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. B. Enson M. D.

Address 4936 Park Heights Ave Date signed 4-21-44

42 Wallenmeyer md

G 16432 G 16482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Valley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hudgins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widwed

6 (b) Name of husband or wife Ida M. Shaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/1868

8. AGE: Years	Months	Days	If less than one day
76	1	5 6	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Isaac Hudgins
13. Birthplace ? England

MOTHER
14. Maiden Name Barbara Hermigan
15. Birthplace ? Balto Md.

16 (a) Informant Little Sisters of the Poor
(b) Address 1202 Valley St. Balto-a-Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Baltimore Md Valley Ave

18 (a) Funeral director John F. Dillon
(b) Address 1 E Lanvale St

19. (a) APR 24 1944 (b) Interring for Williams & Mitts
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION 2 p. m.

20. DATE OF DEATH April 23 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1944, to April 23 1944, and that I last saw him alive on April 23 1944.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to	
Due to Chronic Myocarditis	3 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Gill Hall M. D.
Address 1631 E North Ave Date signed 9/24/44

G 16483 G 16483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/186a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 10 8-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2036 E. Hoffman St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam John Lockman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Carrie Elizabeth Lockman | 6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 20 1873

8. AGE: Years 71 | Months 1 | Days 4 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Lehigh Coal Co

FATHER
12. Name Andrew Lockman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Eberle
15. Birthplace Germany

16 (a) Informant Carrie Elizabeth Lockman
(b) Address 2036 E Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem. Co.
Location Wash. Blvd.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver Street

19 (a) Filed APR 24 1944 Registrar of Vital Statistics
VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944 at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1944 to April 23 1944, and that I last saw him alive on April 23 1944.

Immediate cause of death: Hypostatic Pneumonia — Duration

Due to

Due to

Other Conditions: Intratrochanteric fracture-left
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence April 13 '44 at 4P. M.
(c) Where did injury occur? 2036 E. Hoffman St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped and fell down front steps

23. Signature Helen F. Yeomans

Address St Joseph's Hosp Date signed M. 4 D. 23 '44

Approved: Robert Lee Graham M.D.

G 16484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16484 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2433 E. Jefferson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Charles E. Krause

6 (c) If alive, give age: 1865 years

7. Birth date of deceased (mo., day, yr.): Oct 29-1875

8. AGE: Years: 78 | Months: 5 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Baltimore - Maryland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: George Spohn
13. Birthplace: Switzerland

MOTHER
14. Maiden Name: Antoinette Schott
15. Birthplace: 2433 E. Jefferson St

16 (a) Informant: Bertha Spohn
(b) Address: 2433 E. Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 24-44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Maryland

18 (a) Funeral director: John C. Miller Funeral
(b) Address: 2435 E. Oliver St

19 (a) APR 21 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 at M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an (Autopsy or Inquiry) thereon and from the evidence obtained by said (Autopsy or Inquiry) find that said deceased came to death on the day stated above.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.D. Medical Examiner

Date signed

V8 6

G 16485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 16485 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Myrtle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Pedro Fonseca

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Hurley Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4 1895

8. **AGE:** Years 48 | Months 2 4 | Days 17 | If less than one day hr. min.

9. Birthplace Portugal (town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Pedro Fonseca
(b) Address 1415 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. Laura V. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) APR 24 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION 12:40

20. DATE OF DEATH April 21, 1944, at A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Hisa death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed April 21, 1944.

G 16486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G 16486 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 W. Hughes
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 W. Hughes (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 1896

8. AGE: Years	Months	Days	If less than one day
57 56	8	11	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name Mary Francis
15. Birthplace Md

16 (a) Informant Clarence Diggs
(b) Address 519 Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 20-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director James A Stamps & Sons
(b) Address 1442 W. Pratt St. Baltimore, Md

19 (a) (b) Registrar
(Date rec'd by Local Registrar) APR 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 21 19 44 at 10 a M

21. I certify that death occurred on the date above stated, that I attended deceased from March 19 44 to April 21 1944, and that I last saw h alive on April 20 1944.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E Dayton M. D.
Address 1016 W. Pratt Date signed 4-22-44

G 16487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16487 Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 538 n. Carrollton ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 n. Carrollton ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Britton Richardson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Fem. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hemsley Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-'90

8. AGE: Years 54 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace St. Mary's Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

MOTHER / FATHER
12. Name Samuel Briscoe
13. Birthplace Md.
14. Maiden Name Rachel Green
15. Birthplace Md.

16 (a) Informant Hemsley Richardson
(b) Address 538 n Carrollton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

APR 24 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21- 1944 at 10 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10- 1943 to 4-21- 1944. and that I last saw h e alive on 4-21- 1944.

Immediate cause of death Cardio-Renal Vascular Disease — Duration 4 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Briggs, M. D.
Address 1516 n. Mount St. (17) Date signed 4-22-44

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G 16488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 16488 Registered No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County a.a. Co.
(c) City or town Riviera Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. Rural (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME WILLS, JAMES

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Elsie C. Wills
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) JAN 14, 1872

8. AGE: Years	Months	Days	If less than one day
72	3	8	hr. min

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation druggist
11. Industry or business Retired

FATHER
12. Name Irving C. Wills
13. Birthplace Va

MOTHER
14. Maiden Name Margaret Cobb
15. Birthplace Va

16 (a) Informant hospital records
(b) Address

17 (a) Burial **(b) Date thereof** 4/25/44 (month) (day) (year)
(Burial, ~~cremation or removal~~)
(c) Cemetery ~~or crematory~~ Glen Haven
Location a.a. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address [illegible] St. Paul St

19 (a) [illegible] **(b)** [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1944, to 4-22 1944, and that I last saw him alive on 4-22 1944.

Immediate cause of death	Duration
meningitis	
Due to meningococcus	3 days
Due to	
Other Conditions pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 4-23

G 16489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

G 16489 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 426 N. Exeter St #2 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford Rose Jr.
3 (b) If veteran, name war — 3 (c) Social Security Account No. none
4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11 17 1936
8. AGE: Years 7 | Months 6 | Days 5 | If less than one day 1 hr 20 min.
9. Birthplace West Virginia (City, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Clifford Rose Sr.
13. Birthplace West Virginia

MOTHER
14. Maiden Name Odell Tucker
15. Birthplace Virginia

16 (a) Informant Mrs Clifford Rose Sr
(b) Address 426 N Exeter St.
17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4 25 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 121 St. Paul St
19 (a) (Date received by registrar) (b) Registrar

Huntington West Virginia

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1944 at 1:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22 1944 to 4-23 1944 and that I last saw him alive on 4-22 1944.

Immediate cause of death Respiratory failure. — Duration 20 MIN.

Due to Uremia. — 5 days

Due to acute Glomerular Nephritis — 9 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-20-44

Major findings of operation: Enlarged Hemorrhagic Kidneys.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. R. Riegle M. D.
Address Mercy Hospital Date signed 4-23-44

G 16490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16490 Registered No. 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Kendall

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-20-44

8. AGE: Years	Months	Days	If less than one day
		2 days	hr. min.

9. Birthplace Md Gen Hosp (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name E. W. Kendall
13. Birthplace N. C.
14. Maiden Name Talia Lee Whitlow
15. Birthplace N. C.

16 (a) Informant E. W. Kendall
(b) Address 2917 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 121 St. Paul St.

19 (a) (Date received) APR 24 1944 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22- 1944 at 11 AM/PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1944 to 4-22 1944 and that I last saw h alive on 4-22 1944.

Immediate cause of death premature infant (prematurity) — Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Mitchell, M. D.
Address Md. Gen. Hosp. Date signed

16491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 16491 / 1944 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd
(c) Hospital or institution: Harford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Foudray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband William Foudry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21st 1854

8. AGE: Years	Months	Days	If less than one day: hr.	min.
85	0	1		

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Charles Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Dietz
15. Birthplace Md.

16 (a) Informant Mrs Arthur Schuepfe
(b) Address 4706 Frederick Ave

17 (a) Burial (b) Date thereof 4/25/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Presbyterian Govans)
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) APR 24 1944 (b) Huntington Williams, M.D. Registrar
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22nd 1944, at 2 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1943 to April 22 1944.
and that I last saw her alive on April 22 1944.

Immediate cause of death	Duration
Acute myocardial Failure	5 days
Due to Chronic myocarditis	
Due to Malignant hypertension	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M.D.
M. D.
Address 4706 Harford Road Date signed 4/25/44

VS 180

G 16492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G 16492 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Clifton Park Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Clifton Park Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Stamatiadis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1872

8. AGE: Years	Months	Days	If less than one day
72 62			hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Stamatiadis
13. Birthplace Greece

MOTHER
14. Maiden Name Kalispa
15. Birthplace Greece

16 (a) Informant Athena Christou
(b) Address 3616 Clifton Pk. Ter.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-24-44 (month) (day) (year)
(c) Cemetery or crematory Tarpon Springs Fla.
Location Tarpon Springs Fla.

18 (a) Funeral director William Cook Inc
(b) Address 17[illegible] St Paul St.

19 (a) APR 24 1944 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944, at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral edema
generalized arteriosclerosis;
myocardial fibrosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed April 23 1944

VS 151

16493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 16493
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1648 CHILTON ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1648 CHILTON ST. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country BALTIMORE

3 (a) FULL NAME Edna E. Bolton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Daniel F. Bolton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1872

8. AGE: Years	Months	Days	If less than one day
72	3	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Charles Gallion
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine V. Hall
15. Birthplace Md.

16 (a) Informant Walter E. Ford
(b) Address 1648 Chilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Edgar O. Mitchell's Sons
(b) Address 1900 Eutaw Place Williamsport, Md.

19 APR 24 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944, at 3.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1943 to Apr 21 1944 and that I last saw her alive on Apr 9 1944

Immediate cause of death	Duration
Acute Cardiac Dil	1 day
Due to	
Due to Chron Vab. Heart Dis Hypertension Heart Disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Meyer D.
Address 1520 E. 33rd St. Date signed 4/28/44 M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 16494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16494 Registered No. 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address B'way & Fairmount Ave.
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs 27 mins
(e) Length of stay in Baltimore (yrs., mos., or days) ~~2 hrs 27 mins~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6900 Mornington Rd. Dundalk Md
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Turner

3 (b) If veteran, name war	3 (c) Social Security Account No.
0	0

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	infant

6 (b) Name of husband or wife 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/44

8. AGE: Years	Months	Days	If less than one day
			2 hrs 27 min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation infant
11. Industry or business none

FATHER
12. Name Willis Clarence Turner
13. Birthplace Auglaize Co., Ohio

MOTHER
14. Maiden Name Florence Rebecca Nutt
15. Birthplace Mercer Co, Ohio

16 (a) Informant mother father
(b) Address 6900 Mornington Rd., Dundalk, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof April 21, 1944 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Frederick Rd.

18 (a) Funeral director H Wetzke
(b) Address 4[illegible] Edmondson Ave

19 (a) 4/22/44 (Date received by Registrar)
Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1944, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9 A.M. 4/21/44 to 11 A.M. 4/21/44, and that I last saw her alive on April 21 19 44 at 11 A.M.

Immediate cause of death intracranial hemorrhage — Duration

Due to Cesarean Section

Due to

Other Conditions hemorrhage into left adrenal; bilateral club foot; cong. absence of left radius; cranial aplasia

(Include pregnancy within 3 months of death)

Date of operation 4/21/44

Major findings of operation:

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Thomas Selth, M.D.
Address C.H.H. Date signed 4/21/44 M D

Please write clearly. Physicians: please write the causes of death clearly and legibly. It is especially important.

16495 G 16495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 46B Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Maryland General Hosp. 1944
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Orleans Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Nicholas Berkenhaier

3 (b) If veteran, name war

3 (c) Social Security Account No. 150 18 8937

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Susanna Berkenheier

6 (c) If alive, give age 65 Years

7. Birth date of deceased (mo., day, yr.) Sept 25th 1879

8. AGE: Years 64 Months 6 Days 28 If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Berkenheier

13. Birthplace Hungaria

MOTHER 14. Maiden Name Susanna Orenfold

15. Birthplace Hungaria

16 (a) Informant Susanna Berkenheier

(b) Address 1643 Orleans av

17 (a) (Burial, cremation, or removal) (b) Date thereof 4th 26th 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location

18 (a) Funeral director A. Jones

(b) Address 111 S. Gilmor st.

APR 24 1944 (Date received by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 1944, at 6.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1944, to 4-23 1944, and that I last saw him alive on 4-23 1944.

Immediate cause of death Intestinal obstruction

Duration

Due to Inoperable abdominal Ca.

Due to

Other Conditions over

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. W. Traynor M.D.

Address Md. General Hosp. Date signed 4/24/44

G 16496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G 16496 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 518 S.Madeira Street

(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 21, (If outside city or town limits, write RURAL and give town)

(d) Street No. 518 S.Madeira Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph F.Sobczak

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-9487

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of wife Cecelia -Ratajczak

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) July 8th, 1893

8. AGE: Years	Months	Days	If less than one day
50	9	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Fairfield, Ship Yard.

FATHER 12. Name Matthew Sobczak

13. Birthplace Poland.

MOTHER 14. Maiden Name Anna Studzinski

15. Birthplace Poland.

16 (a) Informant Cecelia Sobczak (Wife)

(b) Address 518 S.Madeira Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-44 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Baltimore, Md.

18 (a) Funeral director George A. Weber

(b) Address 705 South Ann Street

19 (a) APR 24 1944 (Date rec'd by registrar) (b) [illegible] Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22nd 1944, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944 to April 22 1944 and that I last saw h[illegible] alive on April 21 1944.

Immediate cause of death Coronary Thrombosis

Due to Ch. Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Operation 4/20/44

3/1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J Roarer M. D.

Address 601 Kenilworth Dr. Date signed 4/24/44

VS 180

Please write the cause of death very clearly and legibly. Physicians: please write correct age in years. If under one year, give months or days. If under one day, give hours or minutes. Be especially important.

16492

452579

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 16497.
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Reisterstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Sipple Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Lewis (Margaret V. Diver)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Charles
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) 6-11-1876
8. AGE: Years 67 | Months 10 | Days 12 | If less than one day: hr min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Thomas Kearney
13. Birthplace Pa.

MOTHER
14. Maiden Name Agnes Whelan
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co. Maryland
18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

APR 24 1944 (Date received by registrar) (d) Huntington Williams M.D. (Signature of registrar)

VS 150

PLEASE WRITE correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1944 at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1944 to April 23 1944 and that I last saw her alive on April 23 1944

Immediate cause of death: Staphylococcus Bronchopneumonia — Duration: 13 d
Due to
Due to
Other Conditions: Hypertensive Cardiovascular Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Johns Hopkins Hosp. Date signed 4/23/44

G 16498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 16498 / 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 McCulloh Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Martha Sophia McGrady

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	A. A.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1900

8. AGE: Years	Months	Days	If less than one day hr.	min.
43 43	11	7		

9. Birthplace Somerset Co, Eastern Shore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George McGready
13. Birthplace Eastern Shore, Md

MOTHER
14. Maiden Name Mary Stewart
15. Birthplace Eastern Shore, Md

16 (a) Informant Mrs. Mary Murphy Cisler
(b) Address 1807 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. U. Kelagan
(b) Address 1308 Eastman St

19 (a) APR 24 1944 (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 1944, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14 1944, to 4/21 1944 and that I last saw h[illegible] alive on 4/20 1944.

Immediate cause of death Coma
Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration: 7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carson C. Johnson
Address 1804 Penna Ave Date signed 4/22/44 M. D.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G 16499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

G 16499 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3816 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3816 Roland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma K. Gore Rogers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: George Wilson Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17-1861

8. AGE: Years 83 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Washington D. C. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Michael Gore
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Snyder
15. Birthplace Maryland

16 (a) Informant Lindsay Rogers
(b) Address 175 Riverside Drive New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 24-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) [illegible] Registrar
APR 24 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1944 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1944 to April 22 1944.
and that I last saw her alive on April 22 19 44

Immediate cause of death: Myocardial Insufficiency — Duration: 2 hrs
Due to
Due to Adeno carcinoma of Rectum — Duration: 2
Other conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature [illegible] M. D.
Address April 22 44 Date signed
8424 Chestnut Ave

G 16500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registration No. G 16500 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2422 McCulloh St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mollie Pollard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife Wm. Pollard
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Sept 7 1865

8. AGE: Years	Months	Days	If less than one day
73	7	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business own home

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Mollie Brown
15. Birthplace Maryland

16 (a) Informant Wm. A. Roberts
(b) Address 1510 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 572 N. Carrollton Ave

19. (a) (Date rec'd by registrar) (b) Hunting for Williamsport, Md.

APR 24 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19- 1944 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15- 1944 to 4-19-1944, and that I last saw her alive on 4-19 1944.

Immediate cause of death	Duration
Lobar pneumonia	5 days
Due to Exposure to Senile	
Due to	
Other Conditions Myocardial degeneration	unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 4-20-44

CITY HALL

BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 7/23 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 1 3451 AND ENDING WITH 10500 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

END OF REEL